HEALTH
NG
Number 4

The Responsibility of the Board to the Community

Olive A. Colton

Sight Conservation in a School Health Program

Mary Emma Smith

Pernicious Anemia

Mary M. Richardson

Child Health Recovery

Martha M. Eliot, M.D.

Biennial Convention Program

PUBLIC HEALTH NURSING

Official Organ of The National Organization for Public Health Nursing, Inc.

VOLUME 26 APRIL, 1934 Number 4

CIVIL WORKS PROJECTS

While it is too early to evaluate the work being done by nurses in the Civil Works Projects, the N.O.P.H.N., rounding up the experience of the country as reported in correspondence and on field visits, feels encouraged with the progress of plans and with the evidence that there will be lasting good to the public health field from this national experiment. The suggestions of national and Federal agencies were met by state and local supervisors with imagination and resourcefulness and they have produced programs and arranged projects which at first seemed impossible. At the same time there has been a determined effort on their part to hold to the best standards of service while meeting the needs.

One of the outstanding benefits of this experience has been a closer union between all groups of nurses within a given state. Through the state advisory committees has come about a better understanding of one another's problems leading to a broader knowledge of each other's fields. Opportunities for learning the fundamental principles of public health nursing have been opened to the graduate nurse, and in turn, public health nurses have been thinking more than ever before in terms of the complete community nursing problem. Much credit is due these state advisory groups who have struggled to secure the "fundamental safeguards" recommended by the three national nursing organizations when Civil Works first became a household word.*

Naturally the first two problems presented to any group planning to use Civil Works nurses were (1) What to give them to do, (2) How to teach them to do it. More than half of the nurses employed on Civil Works projects have had no formal public health nursing experience and nearly all the projects are in the field of public health! Typical projects and a report of what the N.O.P.H.N. has tried to do to assist in plans were given in the March number of this magazine. An evaluation of results will appear in a later number. This editorial attempts to cover two points—(1) To report on some of the statewide plans for introducing Civil Works nurses to their new jobs;** (2) To offer some suggestions for strengthening the local community programs with a view to capitalizing on their experience with health service in the last six months.

*See PUBLIC HEALTH NURSING, March, 1934, p. 116.

**We are quoting from only a few that have been sent to the N.O.P.H.N.

INTRODUCING THE CIVIL WORKS NURSES TO THE FIELD

Tennessee, through its State Advisory Committee on Nursing, has prepared an outline of rules and regulations regarding nurses and projects, including material on techniques, procedure, record-keeping, and general policies to be followed under various conditions. Packets of material have been assembled and distributed to supervisors and field nurses and conferences have been arranged and attendance required at stated intervals.

In Virginia a project calling for ninety nurses, ten housekeepers, a statistician, a dietitian, forty clerks, and two stenographers was undertaken in December. The plan was to place "additional nurses only in the counties in which there were well organized public health nursing services, and to have them directly under the supervision, and responsible to, these nursing services. Clerks were added to the services, as well as to the State Office, where additional clerical help was needed."

In January a second project using twenty nurses was started. All the new nurses and the regular staff meet every three months, divided into six districts covering the state. The same general topic is chosen for study in each group. As no more than one district meeting is held each week, it permits the state supervising nurse to attend without being away from her office too long.

New York State is carrying on—among other projects—a statewide school survey under the Department of Education. Nurses have been assigned the specific task of obtaining data on the location of schools, the sanitary conditions in the school itself, lighting, seating, ventilation, and water supply. A very complete outline of points to be checked by the nurses has been prepared and this is carefully reviewed with the nurses before they go into the field. An instruction sheet accompanies the outline.

Iowa has a plan somewhat similar to Tennessee—an outline of regulations and suggested procedures for which the supervisors are responsible. Iowa includes instructions as to bedside service and a policy covering the giving of first aid. The state director of public health nursing is also the state chairman of Civil Works Service for nurses. She writes that nurses are being assigned only to counties or communities where supervision can be given by the public health nurse or nurses already functioning.

Florida has a well planned project including special introductory group conferences with nurses. A folder of reference material is prepared for each nurse according to the project on which she is working. Florida also has arranged to have the local medical groups approve standing orders for all those carrying on a bedside service. This would seem a very wise precaution against possible misunderstanding.

Atlanta, Georgia (to mention only one local situation) is carrying on a program of health education for the public through talks, films and posters, trying to show the value of health service with a view to developing a generalized bedside service.

SUGGESTIONS FOR STRENGTHENING PROGRAMS

While it is not possible to count on the continuance of Civil Works projects and the availability of Civil Works nurses, it is to be hoped that out of the work carried on so widely will grow some realization on the part of the community of the value of health service and an urge to retain or, if that is impossible, to obtain in the near future an organized public health nursing service. Many localities are "knowing themselves" for the first time in a health sense and will not be content to get along without the service of a qualified public health nurse. How completely the local community is made to see its need and shown how to supply it will depend on the publicity activities of the state and local nursing supervisors and —and this seems to us of vital importance—the establishment and use of lay sponsoring committees.

The N.O.P.H.N. has always advocated, and now again stresses, the devel-

opment of local lay committees to sponsor these services, to analyze community conditions, and to give publicity to the need for continued service. It is gratifying to note that Kansas and Nebraska in developing Civil Works programs have outlined plans for local lay groups. These groups have already assisted in arranging for the transportation of nurses and furnishing an office. The N.O.P.H.N. will be glad to suggest how to go about organizing local committees if there are not existing agencies from which they can be developed or to which they can be attached until a permanent nursing service is established with an organization of its own.

The N.O.P.H.N. would be interested in knowing from those in charge of Civil Works nurses what efforts are being made to hold the gains which have been made and also what programs are being worked out for the future, both locally and by states.

CONFERENCE ON GOVERNMENTAL OBJECTIVES FOR SOCIAL WORK

A conference under the auspices of the American Association of Social Workers was held in Washington, D. C., February 16-17, 1934. Miss Alma C. Haupt attended as a member of the Association.

The public health movement as a part of the broad field of social work has an immediate and future interest in this history-making "Conference on Governmental Objectives for Social Work." Never before had social workers from more than fifty-five cities, representing public and private welfare activities in all parts of the country, met together to respond to the challenges of a nation-wide depression. The effect was a new solidarity among the participants and the feeling expressed by many that "social work as a profession is growing up." This meeting is bound to give new stimulus to local chapters of the American Association of Social Workers and new growth to its national organization and to the whole social welfare movement.

The significance of the conference to the welfare of the American people is best shown through some of its recommendations which are listed here briefly:

The Conference opposed the demobilization and termination of the Civil Works program on May 1 unless some better plan is announced as a substitute. This recommendation was made in view of the fact that there is now still a large labor surplus resulting in a wide spread between the number of people wanting jobs and the number of jobs available.

The Conference recommended the continuance of a large federal employment project based upon workers' *qualifications for jobs* rather than on their need for them.

The recommendations favor the creation of a permanent national system of welfare services of the government to insure people against the hazards of economic and social life such as unemployment, old age, widowhood, and other factors interfering with normal self-maintenance.

The Federal Emergency Relief Administration was urged to require, as a general policy, states handling federal funds to substitute cash relief for relief in kind.

The government was urged to work out other methods of utilizing surplus food products than to distribute such products to families on relief.

The Conference endorsed the Federal Emergency Relief Administration's admirable program for caring for transients and suggested the following points for consideration: provision of federal funds for hospital care for transients; the reduction of mass care by giving employment through the Transient Bureaus, the Civilian Conservation Corps, or the Civil Works project so that transients can provide their own food and shelter; the eligibility of transients to workmen's compensation; and an integrated program for the care of local homeless and transient persons as a means of improving the standards of care for both groups.

Adoption of the child labor amendment.

That the principle of fair wage rates established for the Public Works program be conserved.

That housing is the most socially useful element in the Public Works program.

Such far-reaching recommendations might well be discussed at the staff and board meetings of every public health nursing agency in the country as to their effect on all those whom the public health nursing movement tries to serve.

Child Health Recovery Program

By MARTHA M. ELIOT, M.D.
Director, Division of Child and Maternal Health,
U. S. Department of Labor, Children's Bureau

BY the early part of the summer of 1933 sufficient evidence of increasing malnutrition and lack of adequate medical care among children had accumulated to demonstrate clearly the need of a nation-wide child health program that should have as its objectives the location of undernourished and underfed children or of children in need of medical care, and the formulation of ways and means of overcoming undernutrition by more adequate feeding and by the provision of necessary medical care. The Child Health Recovery Conference called by the Secretary of Labor on October 6, 1933, and the subsequent development of plans for increased child health activities in practically every State have made evident both the reality of the need and the nation-wide interest in overcoming the effects of prolonged adverse economic conditions. Everywhere there are evidences of the desire to safeguard the health of children from further effects of these conditions. To assist States in the preparation of plans, the Children's Bureau made available for field work three physicians from its staff and later added to its staff two additional physicians, Dr. Juanita McF. Jennings from the State Bureau of Maternal and Child Health in Kentucky, and Dr. Edith B. Sappington formerly with the State Division of Child Hygiene in California. In addition the American Child Health Association loaned to the Children's Bureau the services of its Medical Director, Dr. Clara Hayes, for part time for three months.

In a majority of the States in which renewed interest in a child health program has become manifest, the lead in the organization of the program has been taken by the State Health Department; in a few by the State Medical Association, the Academy of Pediatrics or the State Relief Administration. In some States, certain responsibilities in connection with the program are being assumed by the organization set up following the White House Conference or by other State-wide children's councils; in certain other States where no State-wide organization of this sort has existed before, formal State committees have been appointed with similarly composed working committees in counties; in still other States, informal groups, usually headed by representatives of the State Health Department have organized a program.

SERVICE PLANS

In accordance with the objectives of the Child Health Recovery Program, the plans that have been or are being formulated are for the most part of a service type and not for the purpose of collecting statistics. In a few States surveys of special counties have been made to obtain sample pictures of the health needs of children under certain conditions. In one county of a northern State where such a preliminary survey was made, 31 per cent of nearly three thousand children inspected by physicians and nurses were found to be in urgent need of medical examination and care. In one county of a southern State, medical examination of nearly one thousand children in the schools disclosed 73 per cent to be undernourished. The economic conditions in both of these counties were undoubtedly bad, but the preliminary surveys served to demonstrate graphically the great need. In the former State, further work is developing in many other counties; in the latter, plans have been made for a State-wide program, but funds have not become available as yet. In many States initial efforts to find children in need of food or of medical care are being con-

centrated in those sections of the State where economic distress has been greatest; in others provision is being made to develop work in all counties.

The willingness of various groups—health, medical, relief, nutrition and lay organizations—to coöperate in the attempt to work out some plan by which children could receive the care needed has been striking. Whenever it has been possible for representatives of the State Department of Health, the Relief Administration, the Department of Public Instruction, the Medical Association, the State Nurses' Association, the Extension Service and other interested groups to get together or confer with each other, plans for a child health program have been outlined that have had not only a direct bearing on immediate problems but also definite possibilities for future development.

HOT LUNCHES IN SCHOOL

The interest of State Relief Administrators to provide more adequately for the children through home relief or by helping with school lunch programs has been most reassuring and in many States has made the child health program possible. The authorization from the Federal Relief Administration to permit the use of Federal funds for hot school lunches for undernourished children from families on relief has been taken advantage of in many States, and, furthermore, has acted as a stimulus to communities to provide similar hot lunches for other undernourished children.

Of special importance to the program has been the development of plans for the medical care of children found to be undernourished or to have physical defects that needed correction. Though payment of medical fees for the initial examination of children to determine their condition has not been possible, in a number of States schedules for the payment of physicians caring for families on relief have been adopted by the State Relief Administration and plans are being made for the care of children found to be ill or having defects seriously interfering with their growth or nutrition. Furthermore in many communities, arrangements are being made by various organizations for medical care of children from families who are not on relief but nevertheless in need—the so-called borderline families. The needs of the children in this group are often—though by no means always—greater than those of children in families on relief.

CIVIL WORKS SERVICE

In December added impetus was given to the whole Child Health Recovery Program by the proposal of the Federal Civil Works Administration that plans be worked out by the Children's Bureau and the various State Health Departments for child health nursing service as a Civil Works Service Project for each State wishing to coöperate. Estimates of the number of nurses and supervisors that could be used to advantage in the child health field were immediately submitted by nearly all State Health Departments and by the middle of February programs were in operation in 30 States and Puerto Rico. Plans for 10 other States have been approved and are waiting the allocation of funds; in two States plans are awaiting approval; in 9 others child health work is being carried on through other nursing projects. By the middle of February, 1,572 nurses, including 106 supervisors were at work on projects planned in consultation with the Children's Bureau. The first group of nurses went to work in Maine on January 4.

In most of the States coöperating in these Child Health Nursing Projects, plans have been developed by the State Health Department working with the State Relief Administration and with a committee of the State Nurses Association to pass on personal and professional qualifications of nurses. In four States, the State Relief Administration has taken the lead in organizing the project; in one the project is being carried out by the Department of Public Welfare under the direction of a pediatrician and public health nurse employed for the project. In many States the advice and assistance and active co-

operation of the State Department of Public Instruction, the State Medical Association, the State Dental Association, the nutritionists of the Extension Service of the Department of Agriculture and active lay organizations have been sought and obtained.

ESSENTIALS IN THE PROGRAM

In working out detailed programs for nurses in the various States, emphasis has been placed, first, on the necessity of adequate supervision of the field nurses, most of whom have not been trained in public health work, and secondly, on the importance of planning a simple program for which definite and detailed instructions could be given to groups of nurses before they were placed in the counties and from time to time thereafter. Even within the child health field it was considered advisable to limit the nurse's activities because of her inexperience and short period of service. In December when the child health nursing project was first proposed to the State Health Departments, the suggestion was made that registered nurses not specially trained or experienced in public health work should be designated as Civil Works Service nurses so that a clear cut distinction would be made by both the public and the nurses themselves between the public health nurse and the registered nurse not so trained. This designation has been accepted very widely.

As a result of requests for some plan of procedure from a number of State Health Departments when the project was first proposed, the following suggestions were made:*

" . . . the program for county nurses. Whatever child health program is undertaken will, of course, depend upon the special needs of each state. . . . A simple school nursing program is one which could be undertaken most profitably in a limited period of time by nurses not trained in public health work, although under the supervision of qualified public health nurses, and would at the same time contribute most toward improving the nutritional condition of children. Such a school nursing program might include (1) weighing and measuring, (2) selection, with the advice of the teacher, of children who are in need of a medical examination, or of more and better food, (3) arrangement with the child's parents and with the local physicians for such examinations wherever possible and for the necessary medical or dental follow-up, (4) arrangement with the local relief administrator for increased relief when necessary, especially in the form of milk, or for medical care, (5) coöperation on a school feeding program with local lay organizations and with nutrition or home economics workers.

"If the child health nursing project continues long enough or if a reasonably satisfactory school nursing program already exists every effort should be made to reach the preschool children and adolescent children who are no longer attending school, with the purpose of finding those who are undernourished or otherwise in need of medical care and of instituting the appropriate follow-up.

"In some communities where the nutritional needs of the children are being satisfactorily met, immunization programs may profitably be undertaken under this child health project, or, indeed, other phases of the general child health program as will fit best into a plan already in operation in a given State."

*Letter sent out by Children's Bureau.

A most helpful outline for a Civil Works Service Nursing Project in the Child Health Program has been prepared and printed by the Division of Child Hygiene of the Minnesota Department of Health. This outline gives suggestions for organization, program, policies, nursing procedures and records, and also detailed instructions to nurses to be given in the Division of Child Hygiene Office before the nurse goes out into the field. It provides a very concrete plan for a child health program.

The work of public health nurses in any child health program, whether it be a specialized one or a part of a generalized program is, of course, essential, for a good program can not be carried forward without them. At the present time when many nurses not trained in public health activities are assisting in some aspect of the child health program, the leadership and guidance given by public health nurses is of even greater importance. In the formulation of each State child health nursing project the Children's Bureau has insisted on the employment of supervisors trained in public health procedure. Much of the present interest in the Child Health Recovery Program can be attributed to the coöperation of public health nurses.

The Responsibility of the Board to the Community *

By OLIVE A. COLTON

Please, Mrs., Miss, or Mr. Board Member, read this! It is from the pen of a former member of the Board of the Toledo (Ohio) District Nurse Association.

I HOPE it may not be too disheartening for you to learn that this is a sermon and that by way of making it orthodox, the text is from the Bible: "We are verily guilty concerning our brother, in that we saw the distress of his soul when he besought us and we would not heed; therefore is this distress come upon us." As another challenge to your forbearance, I have gone back to Genesis and I shall work gradually through the centuries and if there is anyone left in the room when I reach those sweet words of conclusion—there will be an exhaustive exhortation for the present day.

What does the community require of the Toledo District Nurse Association but skilled care of the sick in their homes? My answer is *facts;* facts about conditions in those homes. Every enlightened board works to put itself out of business, to lessen the need for its activities and, of course, prevention is the modern method. In the Eight Degrees of Charity of the second Moses, Maimonides, he lists the steps in philanthropy from that of giving, but giving reluctantly, to the bestowal of bounty in such a way that the distressed may never know their benefactor, while the highest degree is that of the anticipation of poverty by prevention. You are already doing this in a measure, but it is in public affairs that I believe nursing agencies over the country will assume a more conspicuous rôle. The nurses have the facts, it remains for the boards to give them to the community for the healing of mankind.

I have never stood before the staff without feeling humble before their first-hand information. Others may have theories, they have reality. This store of knowledge is like a vein in a gold mine that has yet to be opened. Such valuable nuggets as they bring back to you, must be ground down, minted and polished for current use. Regardless of the value of the dollar, this coin will buy health for the city. To put it in another way, cannot your board organize a bucket-brigade to pass to the public what it so sorely needs to learn, in order to establish social justice? Sounds were in the air all the time, but it was not until the radio came that we were enabled to hear them. So, all through the years of nursing, these women have had within them a vast fund of knowledge usually inaccessible to those forming the policies of the cities.

The problem is two-fold. First, how shall we obtain this information? Second, how shall the board make it public? There is no instant solution to the puzzle and it may be a question on which much counsel must be taken, but that should not mean that it must pass to the following board unsolved. Few nurses have been trained to relate what they see to industry or to government; few know the vital points to ascertain about a family and some cannot do themselves justice in speaking. Perhaps certain ones should carry to you their findings. Undoubtedly records should be enlarged to include matters significant to civic progress. At all costs, statisticians should periodically translate, coördinate, and correlate these case his-

*Presented at the Institute for Board Members, Toledo, Ohio, January 29, 1934.

tories into flesh and blood reports for the benefit of the community. I can only put the suggestion before you and if it have any worth, your organization will study methods.

The second part of the problem is no less baffling. How shall your own group make these facts known? Perhaps it may be the answer to the yearly conundrum of the annual meeting. Or it might be wise to rush into printer's ink, or to have a press conference, or for your members to address other groups. Your Association is equipped to be a service-station to supply the public with its constant need of facts about the causes of sickness and poverty. Distribution of this clarifying information is a question that makes your task one with the national efforts for a wider distribution of the things essential to life itself. Moreover, in Toledo, there is a particular lack of research in their own lines of work by the social agencies. Statistics may seem unimportant to the layman, but they are like boxing the compass to those at sea. They show where you are and in what direction your future lies.

Though not a prophet, nor the daughter of a prophet, it seems to me that public health training schools will soon strive to give students more of a sense of unity among their individual cases; to relate their records to cause and effect in the world today and to teach more of them that the Smiths' and Jones' physical ills are inevitable consequences, not only of heredity and environment, but of our civic disregard of the relentless laws of wholesome food, attractive surroundings, interesting work to keep them abreast of their fellowmen and of enjoyable recreation. Boards should be able to read in statistics what the blight of poverty in the home does in the lives of little children. Really "trained" nurses see the background of disease steadily and life, whole.

Pascal said that there are three kinds of people in the world: first, those who know nothing and do nothing; second, those who know, but do nothing with what they know; and third, those who know nothing but *think they know*. It is the last group that does much harm to humanity. Our former leaders were largely from this body and the havoc caused is teaching us the unpalatable truth that we, ourselves, should know more about what is happening today around us. Of course, at first we resist the demand that we study more, because we are already too busy. As the Egyptians had placed in the tomb with them shabti images, to be punished in their stead for their sins, so do we have shabti alibis for our sins of omission and I suspect that you are ready to bring forth bonafide reasons why, as board members, you can do no more than attend faithfully, as you do, the committee meetings. But alas, the community will require even more of you in future! In the matter of learning, good tidings have recently been proclaimed, for Professor Thorndike, the president of the most learned of learned societies, holds that we are never too old to learn, if the mind is kept functioning by further opportunity and desire. As a board member you can then, by interest and application, keep abreast of your chosen line of work, social welfare, and no shabti can take from you the pretext of being busy. Mosquitoes are busy. Do we not know that their activities extend far into the night, yet they accomplish nothing worth while. If your day is so full that you cannot take any time to read the *Survey*, the nursing magazines, or other publications in your line, and recharge your batteries by lectures on social work, would a few "valiant noes" simplify your life and help you to budget your time? This must be done at once to change the record of the Avenging Angel, for in history there is a page that recounts the great causes that advanced civilization, and to our shame, it is not only the so-called well-to-do, but also the cultured classes, that took no part in them. These important movements have been supported largely by the masses, only here and there has a far-seeing individual, from what should have been the leading class, come forth to battle for his underprivileged brothers. He will feed and clothe them, he will give generously for what he believes

to be for their good, but few in the past have fought to change the conditions that kept the majority below the life-line.

One reason for the suffering prevalent today is that we turned, *not* to the sociologists and economists, but to the business men. Some of them are my helpful friends and I realize that most of them are giving the best that is in them. Many are conscientious, untiring and of signal ability in trade and commerce, but the time and attention needed to achieve the difficult ventures they have undertaken, have kept them from reading the new books on social science, from hearing those who speak with authority on this subject and from contact with those who really know the causes of unemployment, sickness, delinquency and distress. Their executive capacity can teach us much, their practical application of scientific methods should stimulate us to copy them, but is not it *unfair* to expect business men to know things that, until recently, have never been considered part of their province? Do we ask astronomers about surgery, or think less of them for not being experts in economics? We have drawn from our money, not our brain power, to find our leaders. It is the social workers who know today what should be done to establish justice, but, unfortunately, like those mentioned by Pascal, we thought we knew so much, we did not ask their advice in civic matters. To me, one of the most tragic situations is when the staff is more advanced than the board, and when some of them tell me that if they spoke out and told what they had learned about conditions that make profits and unmake men, they would lose their jobs, I put on sackcloth and ashes in lamentation. If the truth will make us free, can the price of social work, in Toledo for instance, be silence? And is it progressive to have only conservative support of the *status quo*, in the favor of the community leaders?

The three types of critics that I find particularly disturbing to my mental equilibrium are those who say almost triumphantly on a gloriously bright day: "Well, this is a weather-breeder all right!" Those who are in accord with you about the benefit of a proposed change, but who invariably qualify it cautiously: "Of course, it's coming—but we are not ready for it yet," and those who hear about a new idea and immediately question, not if it is good or bad, but if it is "radical." After which they close their minds as tight as if one put a cork in a bottle. In my late-lamented early life, I had hoped to outlive the word radical, now I perceive I shall not. This, I hasten to explain, is not because any horoscope indicates my coming demise, but because the very meaning of the word defeats any prospect of our using it. Anything that goes to root bottom, anything that is new, or different from what is, will always be radical. The proposal for public schools was once radical in Ohio and a fearful old gentleman rose in the Legislature with the prayer that God keep them from interfering with parents' right to their own children! Just so the foes of the Child Labor Amendment tried to defeat it with ridiculous bogeys. As Emerson reminded us, people have been stoned to death for things we now talk about at the breakfast-table. Progress comes only by trying out new ideas, otherwise we should still be living in caves. It must have been a brave little group that pulled us out into the light of day. It is for the progress of the human family that we must not silence the social workers with epithets like radical and socialistic. Let us at least hear what they have to say.

You will note that I am "smearing the ungent of expression very thickly in order to cover the thinness of thought" in these remarks, but if there are some who resent my seeming reproach to organizations for not helping more in progressive movements, let me ask how many of them took any part in securing for the under-privileged such acknowledged benefits as old-age pensions, minimum wage, street-trade regulation, playgrounds, unemployment insurance, better-housing, workmen's compensation, or the Child Labor Amendment? Did not these measures concern the welfare of your families? No one knows

better than the public health nurse that they do. These are a few of the preventive means by which misery may be lessened. As an example, take workmen's compensation. That law was passed in Ohio in ancient days, when I was on the Board of the District Nurse Association, and as I try to find a shabti to relieve me of that evaded responsibility, I can honestly say that the first reason the Association gave no testimony, was that we did not even know then that such a preventive effort was being made. The other little shabti is that we believed our province was nursing the sick and we dutifully cared for the laundry-workers who were repeatedly scalded, or the punch-workers who lost fingers for lack of safety-devices, and we accepted it as part of the order of the universe that so many accidents should be normal in our work. When labor asked for compensation for injury, of course the employers were on the other side for they sincerely felt their plants could not afford to carry this insurance load. Labor was left alone to fight it out in bitterness of spirit at our unconcern. Today it is universally approved. It prompted employers to lessen accidents by the introduction of safety devices and far from objecting now, they feel that it is not only humane, but it is that *ne plus ultra* of the modern world—it is good business!

But you answer that you cannot get into politics. That is what the teachers felt. Today in every state in the Union they are organizing to better their own condition and to secure modern schools for more children. They are going into politics to accomplish it. What is politics after all but for human welfare and what could raise it faster to the science of government that it was meant to be, but to have the teachers and such groups as yours participate in it? This will be required of you in the future or yours may be the reproach from other organizations fighting for justice, that came to Crillon from Henry the Fourth when he was absent from battle: "Hang yourself, Crillon! We fought a great fight at Arques—and you were not there."

It was not until their own livelihood was threatened that the teachers saw the need of taking an interest in public affairs. Must we wait until poverty comes nearer to us personally, to grasp its meaning? Naturally, I sense that it is Quixotic for you to charge all the windmills at once, but at least you can be tabulating the evidence that will supply other organizations with ammunition for the fight. Don't bury your talent in fireproof files.

Today the standard of living could be raised many times if we applied the knowledge we have. Think what this would mean in human happiness and the lessening of want. Here is your opportunity. As individuals and in organizations, I know well some of you are working with all your might to better conditions, that you have boosted many a forlorn hope to noble fruition. This Association is blessed with a president who gives her life to put into practice here the advanced ideas of other places. She thinks so often of the sick, that she covets for them nothing less than the most intelligent and kind care, but the community requires that the Association as a unit must act. How can it, if you members do not understand, as she does, and, unfortunately, there is no quick way to learn the lessons from the pages of humanity.

The District Nurse Association rendered a signal service to Toledo in helping secure a full-time health officer, but we have to go deeper and safeguard the benefit for the future, change the charter to provide for a non-partisan health commission that will select a qualified man. This we have known at least ten years. If the hospitals, physicians and organizations had kept this persistently before the public would it not know by this time more about the situation? What will lessen sickness faster than an enlightened health board that will insist on efficient city physicians and a program of health education?

No one sees more clearly than you that the lack of means today for imperative operations will later menace the health of the whole city. Surgeons have reported that in case after case, people

wait for an appendix removal until it has ruptured, because they have no money. Health insurance, the tendency toward group insurance, the increase in health centers, maternity benefits, are these topics included in your educational work? In the bitter Senate fight over the Tugwell-Copeland bill, do any deplore, more than the nurses, the waste of money and life in patent medicines? What testimony are the nursing associations ready to read into that record?

When the Minimum Wage Law for women was passed in Ohio, surely the social workers had witnessed that underpay led to malnutrition and other avoidable ills, but a few years ago when the bill was first introduced and those advocating it endured attack and opprobrium, evidence from your group would have hastened the coming of this helpful legislation. Victory in sixteen states has changed it from a radical to a now generally accepted, conservative measure, yet at first in their resentment the manufacturers actually asked their members not to contribute to any organization endorsing minimum wages for women. Miss Lillian Wald and other national authorities in nursing have gone before Congress with convincing proof to buttress their requests, but too many state and local health groups are mute. At the hearing in Columbus on unemployment insurance, but one social worker from Toledo so loved his fellowmen that he risked the displeasure of his board to testify what his work had taught him.

Organizations cheerfully assumed added burdens when factories closed, but what a tale they could tell of the discouraged, brokendown workers whom charity has carried until the plants needed the men and women again. Unemployment reserves, or insurance, are now so well recognized as essential to a social order where industry will care for its own, that the only debatable point about it today among thinking people, is what form it should take. The bill will undoubtedly come up again in the Assembly. Won't you have some facts ready about what the anxiety and lack of security have done to your families? It is the same with playgrounds and recreation for the poor. Should not your case histories show something of the need for better housing, the location where homes are the most degraded, where rents are wrong, where juvenile delinquency as well as the infant death-rate are highest? Such charts as you have must undoubtedly reveal that death is a respecter of persons—more of those living in comfort than of the destitute.

As for manifesting any concern about having Toledo go backward and accepting inertly the Administration's proposal to return to the discredited way of trying to decrease vice by segregation, shall we be excused from community responsibility about that, just because it is an unpleasant topic? Then take the worst preventable calamity—war. Would not the assembled evidence from the various agencies show what the war did to their families? Surely this testimony is the most urgent, for war destroys all causes. Even the birth-control movement will sooner or later ask your opinion. Obviously you have material enough to turn many tides. Shall we silently succumb in the deluge?

In this connection I am reminded of an epileptic boy in Scotland whom the neighbors tired of supporting. When the Queen was to make a royal progress through the town, they suggested to him that the Sovereign might arrange that he be provided for, if, when she passed, he used the occasion to give a little demonstration of his affliction. But as Queen Victoria approached, the boy was so dazzled by the outriders and the pomp of royalty, that he quite forgot his part in the parade. Later, with much disgust, his friends chided him and climaxed their reproach with this stigma: "Fits, Thamas, is wasted on you!" The moral of the tale you will quickly discern. Do not waste such assets as you have. But as I indicate to you glibly the things that remain to be done, Portia's words mock me: "I can easier tell twenty what were good to be done, than be one of the twenty to follow mine own teaching." Signposts point the way, but they never get anywhere themselves.

To sum up for all board members, until we see ourselves in the poor, until we realize that it is largely owing to good fortune, rather than desert that we too are not struggling under their handicaps, we cannot qualify as good board members. And for the responsibility of volunteers, action, too, is the goal of their service. Why take courses, why learn of the philanthropies, if you do not also use your time, your money, and your influence to open up opportunity for those weighed down—often from no fault of their own? If you have this fellowship with them, try to do something about ignorance, greed, and injustice and to supply the need of beauty in the lives of the poor. Do not merely talk about it. After a long, long silence at a Quaker meeting, a brother rose and announced: "Enough has been said, it is now time to ACT."

Having begun with Genesis you will observe that I mercifully skipped the Middle Ages where charity was enough and that now we are as far down as the beginning of the twentieth century. Here a rude discovery was made. The poor were no longer grateful for crumbs from our tables. They had ceased to say: "God bless you!" They preferred to work and to buy their own bread. Philanthropy labored to do good to the poor, but the old order was gone. If anything on earth could prove it, it is that the arch-conservatives have stated that a new social order is needed. When they say so, it must already be upon us. Feudal doctrine is out-of-date in the social trends today. We are down to 1934 and four plans are being tried out in a turbulent world: Communism, Fascism, Hitlerism, and the N.R.A. The Administration is making a brave experiment with the N.R.A. It has many faults that will undoubtedly be changed by its supporters if given time, but already its critics are seeking to destroy it. What other bulwark against revolution have they to offer, if they would tear that down?

The New Deal is trying to adjust life to reality, to distribute more evenly its good gifts to those who have suffered most from the mistakes in our civilization. It is customary in Europe for men to lift the hat when the dead are carried by. When I see the drab monotony of the daily lives of the poor, their long patience under injustice, their courage when hope itself has deserted them and when I note the heartbreak on many a cold hearthstone, I stand in silent reverence and salute the living: "Verily we are guilty concerning our brother in that we saw the distress of his soul when he besought us and—we would not heed."

Public health nursing associations are probably among the best-loved organizations in social welfare work. You, board members and nurses, through your faithful service, have made them so. The citizens will listen when you have a message for them. You have been blessed as few societies and your work deserves it. But "to whom much is given, of them much will be required." Does not the happiness of future generations require that you and all boards go into the market-place with your facts and say, as the Apostles said of old: "We speak that which we know and bear witness of that which we have seen."

LEADING ARTICLES IN THE AMERICAN JOURNAL OF NURSING FOR APRIL 1934

Pernicious Anemia—Yesterday and Today

By MARY M. RICHARDSON, R.N.

PERNICIOUS, or primary anemia as it is variously called, has been known to medical science for over eighty years. It was first described by Thomas Addison, a British physician at Guy's Hospital, London, in 1849. The disease is sometimes called Addisonian anemia. This is the same physician who first described the syndrome resulting from an insufficiency of the adrenal gland, a disease which also bears his name—Addison's disease. Pernicious anemia has been widely discussed in recent years due to the dramatic strides made in its treatment and practical cure.

In this paper we will endeavor to bring out the highlights of these developments in order to give the public health nurse a proper perspective on the whole matter, and to suggest ways in which she may help in the control of this disease.

Prior to 1926 there was a steady improvement in diagnosis of the disease, but no definitely successful treatment and cure.

The pernicious anemia patient was found to show abnormalities of the blood, the gastro-intestinal tract and the central nervous system.

THE BLOOD

The most characteristic feature in the blood picture is the reduction in red blood cells, often as low as 1,000,000 per cubic millimeter. The average red cell diameter and volume are always increased. The hemoglobin is reduced, but not to the same extent, so that we have an anemia with high color index. The white blood cells show no important change, but there is usually a low white blood cell count. There may be likewise a reduction in blood platelets.

THE GASTRO-INTESTINAL TRACT

With very rare exceptions there is an absence of hydrochloric acid secretion in the stomach. The patient may complain of indigestion and gas in the stomach and intestines. He may show signs of glossitis, all the way from soreness of the tongue to a serious ulcerative condition of the tongue and throat. There may be a constipation or diarrhea or both alternating.

Through many and devious ways those investigators studying the gastrogenous aspect of pernicious anemia came to the conclusion that "there are three possible mechanisms by the action of one or more of which the disease may be produced, namely, the lack of some intrinsic factor of the stomach, the lack of some extrinsic factor in the diet, or a failure of absorption or utilization of the product of the interaction of the intrinsic and extrinsic factors."

THE CENTRAL NERVOUS SYSTEM

If untreated, the pernicious anemia patient may develop degeneration of the spinal cord. This degeneration involves particularly the posterior column, so that disturbances of sensation are very frequent. Almost as frequently there is involvement of the lateral column, producing a condition called posterolateral sclerosis or combined system disease. This produces disturbances of sensation such as numbness and tingling and other parathesias and ataxia. The involvement of the lateral tract produces spasticity, so that the patient's gait is spastic and ataxic. These disturbances of the central nervous system are not necessarily found in the most severely anemic patients, and may be the first symptoms which cause the patient to seek medical advice.

WHAT CAUSES THIS DISEASE

One may say that the direct cause is lack of this "intrinsic factor" in the gastric juice. But what causes this lack? Does it occur suddenly or gradually? The consensus of opinion seems to be that the disease develops gradually. The

patient in early life may have a secondary or hypochromic anemia and later in life have the Addisonian type superimposed. It has been suggested that the tendency to anemia in either form may be hereditary, showing up as secondary anemia in some members of the family and as pernicious anemia in others.

TREATMENT PRIOR TO 1926

The principle of treatment seems to have been along general hygienic lines—well balanced, nourishing, easily digested diets, rest, sunshine, and fresh air. Blood transfusions were also given with some temporary effect, but the disease always terminated fatally in spite of the best medical and nursing care, usually within two or three years. Those of us who have been in the nursing profession ten years or more can well remember these pathetic cases.

HARVARD MEDICAL SCHOOL—GEORGE MINOT

In Europe and America the search for the cure of this disease was being carried on with greater and greater intensity. The disease was thoroughly well understood and yet no cure had been found. It remained for the Boston School "in one of the most beautiful researches in the history of medicine to show that liver, stomach, and kidneys contain a principle curative in pernicious anemia, and that this principle is normally elaborated in digestion by the stomach, and stored in the liver and kidneys." Only after years of careful study and persistent research were the above conclusions finally reached.

Special diets for the pernicious anemia patient were then worked out, consisting principally of foods rich in complete proteins—notably liver and kidneys—and containing also an abundance of muscle meat, vegetables and fruits and low in fat.

Dietitians were called upon to devise means of serving liver in various and palatable ways—liver broth, liver soups, stewed liver, broiled liver, minced liver, liver patties, and so on. Our magazines were full of these menus. All this must have been a tremendous help to the patient with someone at hand to do the cooking, but how very tedious it must have been for the patient who had to do it all herself! No wonder she often gave it up in disgust and consequently suffered a relapse.

Fairly soon after this we find liver extract coming to the fore. This was at first worth its weight in gold, and given only to a few seriously ill patients to start them on the upgrade. As soon as they improved they were placed on the regular liver diet. Gradually the extract became easier to obtain and cheaper forms were developed and made available for all.

HOG'S STOMACH

Concurrently with the development of the liver therapy we find another group of research workers, headed by Elwood Sharp of Detroit, working on the question of the value of actual gastric tissue in the treatment of pernicious anemia. As a result of their investigations, they found that desiccated hog stomach fed to these patients produced satisfactory results, in some cases quite as satisfactory as those obtained by the use of liver. Hog stomach and liver have now been combined in a preparation known as Extralin.

SUMMARY OF SYMPTOMS OF PERNICIOUS ANEMIA

In general, increasing pallor and weariness and exhaustion on the slightest exertion are noticed. Gastric disturbances—nausea and headaches, flatulence—irregular action of the bowels with either constipation or diarrhea are present. There is indifferent appetite, yet a gradual gain in weight. The patient usually presents a well nourished appearance. On examination the blood is found to show a low red count, the red cells being larger in size than normal, a normal white count, and a low hemoglobin. The reticulocytes are few.

RESULTS OF TREATMENT BY LIVER EXTRACT

Changes in the blood—The behavior of the reticulocytes is extremely interesting to follow. Apparently the feeding of liver causes these immature red blood cells which have been crowded in

the red marrow of the bones to be thrown into the blood stream. The lower the red count—in other words the greater the need—the higher will be the number of reticulocytes thus set free. The "reticulocyte response," as it is known, is thus in inverse ratio to the red blood count. This increase of reticulocytes continues usually for eight to twelve days and then disappears. The reticulocyte response is considered an important diagnostic factor.

Most of these reticulocytes develop into mature red blood cells. We thus find the red blood cells of a patient with a very low count increasing at a greater rate than those of the patient with a count around 3,000,000 or more.

The rise in hemoglobin does not seem to keep pace with the increase of red blood cells. It takes very much longer to reach normal, sometimes failing to go above 80 at any time.

At the beginning of his treatment the patient is usually given the maximum dose of liver extract per day. This may be kept up for a month or so, according to how he feels generally. Some patients suffer some intestinal discomfort when starting to take liver extract. The dose may then have to be reduced, or the form of liver extract changed.

FORMS OF LIVER EXTRACT

There are today many forms on the market. The powdered form put up by a well known firm is known as "343." This firm was the first to make liver extract and produced it under the supervision and guidance of the Commission on Pernicious Anemia. Now all good manufacturers of drugs and medicines are putting out different forms of reliable extracts. The latest development in therapy is liver extract for intramuscular injection, which form may be lifesaving in very seriously and dangerously ill patients, and is especially useful in patients with marked involvement of the central nervous system. These patients may be kept well by injections given once every week, two weeks or longer, without needing any other form of liver extract.

There is a liquid extract available to be taken by mouth.

We also find the combination liver extract and hog stomach extract, known as Extralin, put up in capsules. This is perhaps the most convenient form for the patient to take.

When the patient's blood reaches normal, which may take from four to six months, the doctor may gradually reduce the dose until he finds the exact amount that particular patient requires in order to maintain his blood at a normal level.

General Changes—Soon after starting liver therapy the patient feels generally improved: stronger, better appetite, more energetic. The general appearance improves, the pallid, somewhat jaundiced skin becomes clearer and more normal in color. Unless his disease was far advanced before obtaining treatment, the patient is usually able to carry on a normal day's activities and is to all intents and purposes cured.

DIET

Although the diet of these patients no longer plays as important a part as it did, it is still necessary for them to follow a well balanced diet, rich in red meats, vegetables and fruits and low in fats. A sensible regime should be carried out, avoiding excesses of any kind.

IS THE PATIENT CURED?

We must remember that this disease is never *actually* cured, but the patient is as good as cured today if he continues faithfully with his treatment. This must *never* be let up for the rest of his life.

ECONOMIC DIFFICULTIES

There is no question but that the continued expense of the liver may cause a patient to give it up. He should be brought around to the point of view that this expenditure ought to be considered part of his regular food budget; his daily bread substitute. It is a comfort to realize that the preparations of liver on the market today are continually being improved and their prices reduced.

There is also the need of regular visits

to the physician or clinic for check-up on the blood and general health. This is extremely important for patients with this disease. Some physicians feel that the liver extract given hypodermically is to be preferred to other forms, because the patient must return to his doctor or clinic in order to get his monthly dose and may be checked up at these times.

A patient feeling well and continuing with his liver may not see the importance of regular visits to his physician—yet his blood count may go entirely too high without his knowing it, causing a severe drain on the red marrow of the bones; or his blood count may have slipped down, indicating a need for a larger daily dose of liver.

THE PUBLIC HEALTH NURSE'S RESPONSIBILITIES

What can the public health nurse do in this field?

First we might suggest an increased "awareness" to the disease and its implications. Let us have such an interest and clear understanding that we are constantly on the lookout for suspicious symptoms. We must widen the range of our knowledge, watch for possible cases and send them to their physicians or to a clinic for thorough examination, including blood. This type of case finding is along the lines of what we are already doing in tuberculosis and syphilis.

Then there is the diagnosed case. He needs almost the same regular visit of encouragement and check-up as the tuberculosis contact case. He becomes just as dilatory in his visits to clinic or physician as the tuberculosis contact does, unless he is urged and encouraged to do otherwise by someone outside the family who is interested in his case. The nurse can see that he is carrying out his treatment, and be on hand to strengthen the advice given by the physician.

BIBLIOGRAPHY

Castle, William B., and Bowie, Morris A. "A domestic liver extract for use in pernicious anemia." Journal of A. M. A., June, 1929.

Minot, George R., Murphy, W. P., Cohn, Edwin J., Stetson, Richard P., and Lawson, Herman A. "The feeding of whole liver or an effective fraction in pernicious anemia. The response of the reticulocytes." Transactions of Assn. of American Physicians, Vol. XLII, 1927.

Minot, George R., Cohn, Edwin J., Murphy, W. P., and Lawson, Herman A. "Treatment of pernicious anemia with liver extract." American Journal of Medical Science, May, 1928.

Minot, George R., Cohn, Edwin J., *et al.* "The nature of the material in liver effective in pernicious anemia." Journal of Biol. Chem., July, 1927.

Minot, George R., Murphy, Wm. P., and Stetson, Richard P. "The response of the reticulocytes to liver therapy particularly in pernicious anemia." American Journal of Medical Science, May, 1928.

Minot, George R., and Murphy, Wm. P. "A special diet for patients with pernicious anemia." Boston Medical and Surgical Journal, August, 1926.

Nicholls, Elgiva A. "Suggestions for the administration of the Minot and Murphy special diet for pernicious anemia." Boston Medical and Surgical Journal, February, 1927.

Sharp, Elwood A. "An antianemic factor in desiccated stomach." Journal of A. M. A., September, 1929.

Strauss, Maurice B., and Castle, William B. "The nature of the extrinsic factor of the deficiency state in pernicious anemia." New England Journal of Med., July, 1932.

Sturgis, Cyrus C., and Isaacs, Raphael. "Desiccated stomach in the treatment of pernicious anemia." Journal of A. M. A., September, 1929.

Witts, L. J. "The pathology and treatment of anemia." Lancet, 1932.

Our supply of January, 1934, magazines is almost exhausted. Will any reader who has finished her copy and does not need it, send it to the Business Manager, N.O.P.H.N., 50 West 50th St., New York, N. Y. Postage will be refunded. Thank you.

Nurse-of-the-Month

MARY E. WADE
Maine

Mary E. Wade is a graduate of St. Luke's Hospital, New Bedford, Massachusetts, and had her public health training at Simmons College in Boston. She was for six years a member of the staff of the Boston Community Health Association, two years with the Brookline Friendly Society, and one year as Supervisor of the District Nursing Association, Newport, Rhode Island. She has been in Maine since August, 1930, doing rural health work in the towns of Livermore and Livermore Falls.

PUBLIC HEALTH NURSING IN RURAL MAINE

THE village of Livermore Falls is situated in the west central part of Maine on the Androscoggin River. It is a hustling manufacturing village containing one of the largest paper mills in the country. As this industry is not a seasonal business, but furnishes all year round employment, it eliminates the floating population which is so often found in most manufacturing towns. Many of the employees own their own homes, which tends to make them more interested in civic affairs and more stable citizens. There are also canning factories, corn, bean, and apple, which provide seasonal employment for many women in the community. There are, too, a glove factory and a foundry.

The adjoining town of Livermore is a farming district. The produce raised is sold to the canning factories, and milk is sold to the local branch of a large New England creamery. This part of Maine is one in which apples are grown successfully. Many barrels are shipped to other sections of the country yearly.

The area including a radius of thirty miles covered by the nurse has a population of 4,261; and a school population of about 900. There are three town schools, including the high school, and ten rural schools.

The service embraces school work, control of communicable disease including tuberculosis, home visits to prenatals, infants, and preschool children. The major project centers around the school with the inspection of all children by the nurse soon after the opening of school, and follow-up visits to the home regarding defects observed. Infant and preschool conferences are held once a month with a physician in attendance. Arrangements are made with the State Bureau of Health for two weeks of service from a dental hygienist in each

town, and assistance is given the worker.

In January of each year diphtheria immunization is offered. Parents are urged to have their children receive this protection. About eighty per cent of all school children are protected and one-third of the preschool group.

A tentative plan of work is arranged by the nurse for each month. The services to be rendered are listed and the best time for carrying them out is planned with a view to the difficulties of transportation, for in some of the more isolated sections of our territory during the winter months the heavy snowfalls make traveling difficult.

While Maine has not been affected by the depression as much as other sections of the country, the average family income has been reduced considerably. During the past two years some of the nurse's time has been spent in direct family relief work and in assisting the various welfare organizations in the community to carry out relief programs. There has been an unusual need to help the family to adapt itself to any altered financial status and to follow an approved dietary, and to plan a wise expenditure of income. The two latter objectives have been promoted so far as possible by distributing helpful literature on malnutrition and suggesting healthful menus obtainable at low cost.

Regular meetings are held with the Health Committee, comprised of interested local people who work with the nurse in helping the people of the community to understand better the value of the service. Through this committee and through assistance given to the various local relief organizations, the nurse is able to serve the area widely and at the same time demonstrate to the people the scope and value of the health service.

Prenatal Chart

Last month we published an outline of teaching points to be included in giving postpartum care. The accompanying chart is from the same staff (Visiting Nurse Association, Scranton, Pa.).

EXPLANATION OF CHART

Month of contact means the month of pregnancy in which case is admitted for care. The number in the blocks indicates the approximate number of visits that it will be possible to make on a case during the period of care. This figure also indicates the content of the visit. For example: A case is opened in the fifth month. On the first visit an effort will be made to cover the teaching points in the first and second columns; on the second visit the third and fourth columns, etc. Or suppose a case is opened in the eighth month, when we may be able to get in four visits: on the first visit we will stress columns 1, 4, 5, and 6. On the second visit columns 5 and 6, etc.

Comments: It is not always possible to live by the letter of the law, but certainly we do avoid discussing diet for bone formation in the eighth month and many other equally ludicrous misapplications of teaching. The nurse, of course, is supposed to use her guide according to the individual needs of the patient.

Certainly the outline makes for more consecutive teaching. We find it particularly helpful if it is necessary to use relief nurses on prenatal cases.

Up to the time we worked this out we felt that the nurses were too inclined to make the "how-do-you-do" type of visit: "How are you today, Mrs. X.? Did you start your baby clothes? You've been to the doctor! Good! What about that tray? So Jane is getting curious? Well, you seem to be all right, Mrs. X. I'll be around again in two weeks. Watch your diet! Good-bye."

OUTLINE FOR VISITING PRENATAL PATIENTS

Month of Contact	The number indicates content of visit and number of visits during the period of care, to be discussed and selected according to importance in relation to the time case is opened									
2nd or 3d	1	2	3	4	5	6	7	8	9	10
4th	1	1	2	3	4	5	6	7	8	9
5th	1	1	2	2	3	4	5	6	7	8
6th	1	1	2	2	3	3	4	5	6	7
7th	1	—	1	2	1 + 2	3	3	4	4	5
8th	1	—	—	1	1 + 2	1 + 2	3	4	4	1 + 1
9th	—	—	—	1 + 2	1 + 2	—	—	—	2	—
Throughout pregnancy emphasis on medical supervision and mental health, and diet in relation to comfort and safety	A.P. Care: what it is and why necessary Naturalness of pregnancy Parents' attitude toward pregnancy Personal Hygiene (emphasis on bathing)	Nutrition of pregnancy, best food at lowest cost Method of nutrition of fœtus Growth of fœtus in utero (Chart) Dental Hygiene Correction of physical defects	Clothing of mother Exercise, rest and fresh air Routine of day The job of being parents Quickening Danger signals	Care of breasts and preparation of breast tray Preparation of other children in family for coming baby Suggest materials for mother's and baby's tray Baby clothes	Set up of tray and use Plans for delivery room, etc., disposition of children Descent of baby down birth canal Use of labor pains What to do when labor begins	Draw husband into plans Continuance of social contacts Sexual relations Diet last two months of pregnancy	Reinforce past teachings Instruct use of potty; beginnings of habit formation; schedule; environment, etc. Baby's own bed and room if possible	Lightening Relation of breast feeding to involution of uterus Care of baby until arrival of nurse Stress importance of postpartum examination	Check on plans and careful attention to danger signals Mental encouragement Inspection of trays and equipment for mother and baby Diet hints for mother after delivery in relation to baby	Review record and place emphasis where needed most

Content of individual visit—covering a complete pregnancy cycle

Sight Conservation in a School Health Program

By MARY EMMA SMITH, R.N.

ONE of the reports[1] recently issued by the research group of the American Child Health Association contains a challenge to all who are participating in school health programs. Those who have read the monograph, or the summary of it which appeared in PUBLIC HEALTH NURSING,[2] will recall that the findings of the survey show that school health procedures have not made the changes in the lives and health of children that are desirable and which they are designed to accomplish. If this is true (and some of us have long suspected it) now is the time to begin a reconstruction in this field of public health.

The situation calls for a complete overhauling of the entire mechanism, with due consideration to all phases of the health program. As an illustration of how this may be accomplished and because there will always be a carry-over of method from one part of the program to every other part, I wish to give here some suggestions for the improvement of the phases of the program which have for their purpose the promotion of eye hygiene, particularly the activities that are carried on by the school nurse.

POINTS OF FAILURE

An Evaluation of School Health Procedures, the report mentioned above, states, among other things, that fourteen per cent of the fifth and sixth grade children tested had evidences of uncorrected vision defects in one or both eyes which were at least as serious as a visual acuity of 20/40 according to the Snellen scale, and that only fifteen out of every hundred were known to teachers and nurses as children who might have serious eye conditions. The investigation indicated that the teacher has an important function in selecting and referring the child for examination and follow-up, but the full possibilities of this function have yet to be developed; that the nurse-teacher rapport is one of the most vital factors in providing results in a health program, but this factor needs much improvement; that the teacher- and nurse-knowledge most valuable to school health is knowledge of the child and method rather than professional information, and this knowledge is inadequate; and that there is much room for improvement in the home visit made by the school nurse.

The authors[2] raise these questions: Where should the responsibility lie for seeing that important defects are followed through until they reach professional attention? How can the nurse and teacher be brought closer together? How can the nursing profession get examination techniques which are better adapted to its needs? Does the school nurse need more and better social service training?

WHY DO NURSES NOT KNOW OF EYE DEFECTS?

A part of the school population will be found to have evidences of visual defects for which they must have professional care if serious results are to be avoided. The study shows that the school health procedures are not adequately providing for this group, because a large number of children with eye defects are not known to have such conditions.

Since the school nurse plays a part in this failure, it is well to find out something about her. The 1931 Census of Public Health Nursing in the United States,[3] made by the National Organization for Public Health Nursing, reveals the fact that more nurses are employed to give public health nursing care to *school children* than in any other one

field of community nursing. Some nurses give full time to school work, while with others it is only a part of their job. The census shows that 1,348 boards of education employ a total of 2,980 nurses. The majority of these boards (1,049) employ only one nurse. In these one-nurse services, there may be a school physician and there may not. In all probability the nurse will be working with little or no nursing supervision. She may even be inadequately prepared for her job, since her selection for health education work may have been based upon a skill in caring for sick patients. It is not likely that many of the 1,049 situations, in which only one nurse is employed, will have a person to integrate the work of all people in the school system interested in the health of the pupils.

WHO IS RESPONSIBLE FOR SECURING PROFESSIONAL ATTENTION?

The question, "Where does the responsibility lie for seeing that important defects are followed through until they reach professional attention?" seems easy to answer, because we know the school administrator must assume responsibility for the success or failure of all work in his school including the health program. As a rule, however, he is more interested in pedagogies than in health. Because of this, he may require the personnel employed to supervise the health of pupils to function in the manner that best facilitates the smooth running of the classroom activities. Often this puts health supervision on an unsound educational basis. Frequently wide latitude is given to the school nurse in working out her program. This is desirable, but she may have no knowledge of program-making or even what activities should be included in her part of the program. These conditions will not produce health procedures capable of effecting beneficial changes in the lives of children.

DOES THE SCHOOL NURSE NEED SOCIAL CASE WORK?

Does the school nurse need more and better training in social case work? That can be answered at once. The average nurse does.[4] However, it is not the purpose of this paper to discuss nursing education, except as it relates to the effectiveness of the work. There is a great need for better prepared school nurses, but it is not likely that the qualifications of school nurses will improve very much until boards of education require special training and preparation for the job.

CLOSER RELATIONSHIP BETWEEN NURSE AND TEACHER

How can the nurse and the teacher be brought closer together? It was in response to questions such as this that the National Society for the Prevention of Blindness developed its "Suggestions for a Program of Eye Health in a School System."[5] These suggestions are intended for the guidance of school and health administrators in formulating that part of their health plans which deal with sight conservation. The suggestions deal largely with objectives and with the activities that should be included in such a program, but do not attempt to meet the needs of any particular situation, since each system must work out the program that is needed in that particular community.

OBJECTIVES IN THE CONSERVATION OF EYE HEALTH

The general objective of this program is: To build within the school system a program for using all of the community's facilities to the best advantage, so that everything possible may be done to conserve and promote eye health.

The specific objectives are:

To emphasize the fact that eye health is a part of the general health program of the school.

To develop a coöperative relationship with all agencies in the community having a contribution to make toward a program of eye health.

To encourage the family to assume its responsibility for the conservation of eyesight and the correction of eye defects; but in cases needing assistance to coöperate in making available the resources in the community for remedial care.

To provide a way for the various workers in the school system to share their knowledge of the child's physical condition, so that this

common knowledge can be used to the best advantage for the child.

To give the child the experiences which will enable him to understand the why and wherefore of eye care and to assume his share in the conservation of his sight.

These objectives, it is believed, represent a sound approach to the solution of the chief problem—teaching the child to take care of his eyes.

AN ADMINISTRATIVE PLAN

Definite administrative procedures will be necessary in order to produce a coöperative working relationship for all participants in the program. Consider the knowledge that must be shared before the nurse can make a profitable visit in behalf of a child with a vision defect. She should have the benefit of all information having any relation to the case which is in the possession of teachers and others in order to handle the matter in an economical and efficient manner. The teacher, on the other hand, should have the benefit of the knowledge gained by the contact with the home so that she can better understand the child.

The teacher will know about the child's behavior before and after studying, and his posture. She will know whether he is retarded in his work, whether there have been styes or other evidences of an inflammatory condition, of running eyes, whether he complains of not seeing the blackboard, and other matters of this nature. The teacher should also know his visual acuity. The nurse will want to know all of these things and more. Are there sisters or brothers in school known to have eye troubles? If so, does the school have a record of the eye conditions? If the child is retarded, could it have been due to some illness or to irregular school attendance? If the child is unable to see the writing on the blackboard, is this due to an insufficient amount of light on the board, to glare, to illegible writing, or to the distance he sits away from the board? What is the amount of light on his desk and its direction? Is the type in his books suitable for his age? Does the child have colds, sore throat, or other illnesses? Does he seem to be well nourished? Does he have a sufficient amount of rest? These are a few of the things that will need to be discussed by the teacher and nurse. A desire not to leave any stone unturned in order to give the child the best protection that is possible with the facilities at hand will bring them closer together.

PLANNING SYSTEMATIC REPORTS

A weakness in some schools is the careless manner in which information about important matters is given by the nurse to the teacher. The nurse will have a body of information about the child's eye condition and data pertaining to it that will be needed by the teacher. Often definite instructions must be issued, as for instance in the prevention and control of communicable eye diseases. These instructions, which must be definite and concise, should be typed or mimeographed on paper of uniform size so that they can be filed for permanent use, or until they are replaced by information based on more recent knowledge.

In order to get vision defects corrected, many separate activities are involved; the child needing care must be selected; parents must be informed of the suspected difficulty and perhaps helped to see and to meet their responsibility; then a careful examination by an eye physician; translating the doctor's instructions to the home and to the school so that such changes as may be necessary can be made in order to accommodate the child's defect. If glasses are to be worn, the child should understand why; much educational work will be needed so that he may develop the new habits necessary for wearing them. It is important, too, for him and others to have the right attitude toward the spectacles. The dates for subsequent visits to the physician must be known, and new teachers must understand the child's condition. The follow-up of vision defects must be a continuous process. It should begin during the preschool age, last through the child's school life, and guide in the selection of an occupation that will be compatible with his desires and abilities.

In order to insure progress, a record

of the eye condition should be available when the child enters school and should accompany him from grade to grade. There is need for much more knowledge than is found on the regular school card; *i. e.*, a space for the record of visual acuity and sometimes space for mentioning other conditions found in the inspection. True, this information is sufficient for the screening-out tests, but for all children suspected of having a visual defect and who are referred for medical examination, much more information will be needed. The school should furnish the doctor making the eye examination with a record of the information possessed by the various workers in the system regarding the child's eye condition. These data will consist of the visual acuity, symptoms noted by the teacher and nurse, other significant information such as retardation, behavior, and personality difficulties, and whether other members of this family have abnormal eye conditions.

The school in turn must have certain confidential information that can be supplied only by the physician: the nature of the eye condition, the visual acuity with a correction, the amount and kind of eye work that is advisable, the ability to study safely in the ordinary classroom situation, the limitation of recreation, if any, and the date on which the child should be re-examined.

The National Society for the Prevention of Blindness is suggesting the use of a special eye record[5] for compiling the information mentioned above. This record is to be used in connection with and as a part of the permanent physical health card. It should be of a color contrasting with the school health record in order to further identify it. There should be some method of signals used on the records in order to call to the attention of the nurse the cases needing urgent follow-up and the dates of re-examination. The records should be available to the teachers and to others in the school system having need of this information.

METHOD OF SELECTING CHILDREN FOR EYE EXAMINATION

The method recommended now for selecting children for eye examination consists of observation of symptoms, a study of the behavior, and test for visual acuity. Many workers complain that these procedures do not screen out the children with visual defects, but it is likely that much of the fault lies in the way in which these activities have been carried on rather than with the method itself. The majority of schools of my acquaintance have made little or no provision for obtaining reliable results from these procedures. This is particularly true of the tests for visual acuity. Schools have failed to provide adequate equipment for making such tests. Frequently a mutilated, old chart, which does not conform to an accurate scale, is the only apparatus available. Too often the person or persons who make the tests have not taken the time to perfect a technique. Until school administrators recognize the importance of providing facilities for making vision tests —a twenty-foot space in a quiet room, an illuminated chart, etc., and for requiring the person making the test to be skillful in this procedure, vision tests will continue to be inaccurate.[6]

It is not the purpose of this paper to say who should make the test, as that must be decided by each system, but rather to emphasize that the person making the tests should take the time to become familiar with the technique and that she should have the equipment necessary for making accurate and comparable tests, which should be made as early in the school year as possible. The nurse must start the follow-up early if results are to be achieved, and the teacher will need a knowledge of the eye and home conditions in order to understand the pupils.

The purpose and limitations of the Snellen chart test are not always understood. It is used as one procedure for selecting children for eye examinations, but it will reveal only a portion of the children with eye defects. Careful tests should select most cases of myopia and the cases of marked astigmatism, although it cannot be expected to detect cases of latent hyperopia. This test must not be considered complete without

the use of a trial case and probably atropin, procedures naturally in the province of a physician.

HOW EFFECTIVE ARE PRESENT PROCEDURES FOR FINDING EYE DEFECTS?

Just how effective the present procedures for finding visual defects might be made has never been determined so far as I know. Research technique would be required to check the efficiency of the method. This could be done by having a carefully trained teacher or nurse working under close supervision make an eye inspection and a visual acuity test with the Snellen chart on a group large enough to have statistical significance. These findings would be considered in connection with symptoms observed by the teacher and with other information that might be furnished by the school and the home. The findings obtained in this way could then be checked against the results secured from complete ophthalmological examinations of the same group of children, including both the ones selected by the teacher or nurse as presumably having defects and those rated as normal. A study of this sort would determine how complete the present screening method is.

It seems to me that a study of this nature is needed because it would determine the value of the present method from the standpoint of selecting children with visual defects, the cost and the time involved. It would be valuable also in that it would provide an opportunity for scrutinizing the whole system of correction of visual defects, the apparatus and methods for selection, and the follow-up program. Weaknesses would be revealed as the study progressed and ways for eliminating them could be evolved.

REVIEW OUR METHODS NOW

One thing that can be done at once is that each person in the school system take stock of his part in the program in order to see where he is falling short. The school nurse may be surprised to find that many of the weaknesses are probably due to the fact that she has not brought these faults to the attention of the administrator and has not given him constructive and practicable suggestions for improving them.

It would be interesting to see what could be accomplished in a school system in protecting the health of the children if the latent strength in the community could be used in a united effort. This would not necessarily call for the employment of specialists, but it would call for leadership in mobilizing and using all the agencies in the community —the health department, medical profession, social agencies and civic organizations.

BIBLIOGRAPHY

1 *An Evaluation of School Health Procedures*, Raymond Franzen, Ph.D. School Health Research Monographs, V. New York: American Child Health Association, 1933. 90 cents.

2 *Looking Ahead with the School Nurse*, George Truman Palmer, Dr.P.H., and Raymond Franzen, Ph.D. PUBLIC HEALTH NURSING, July, 1932. 15 cents.

3 Census of Public Health Nursing in the United States. National Organization for Public Health Nursing, 450 Seventh Avenue, New York City. 50 cents.

4 ***Minimum Qualifications for Those Appointed to Positions in Public Health Nursing in 1935***, prepared by the Committee on Education of the National Organization for Public Health Nursing and endorsed by the Public Health Nursing Section, the Committee on Training and Personnel, the Committee on Research and Standards of the American Public Health Association, March, 1931. PUBLIC HEALTH NURSE, May, 1931. Free.

Minimum Requirements for Approved Postgraduate Courses in Public Health Nursing, PUBLIC HEALTH NURSING, January, 1932.

5 *Suggestions for a Program of Eye Health in a School System*, National Society for the Prevention of Blindness, Inc., 450 Seventh Avenue, New York, N. Y. (Single copies free.)

6 *How to Test for Visual Acuity*, National Society for the Prevention of Blindness, Inc., New York, N. Y. (Single copies free.)

Public Health Nursing for the Employees at Vassar College

By ELIZABETH HALL, R.N.

JUST a year ago, the management of Vassar College decided to try an experiment and added to the staff a public health nurse to work with the employees. This experiment seems to be a successful one and continues. The program concerns adult health and is a sort of industrial nursing service. While it is far from complete, one can see improvements in the system almost daily.

Since Vassar College is one of the largest of its kind in the country, having twelve hundred students, the number of employees is correspondingly large—five hundred. Some live "on campus" and some come in daily. The need for this number of employees is easily understood when one realizes that the college maintains its own power plant for lighting, heating, and disposal of sewage, carpenter shop, plumbing shop, telegraph and telephone office, messenger service, express office, post office, fire and police departments, farm and laundry, not forgetting the twenty-five-bed infirmary for students. There are sixty buildings on the campus, nine of which are dormitories.

The employees are of an exceptionally high type; nearly all have had at least a high school education. They are American born with a few Poles and Germans scattered throughout. The "turnover" is not rapid as workers stay for years, perhaps encouraged by the pension system which exists. They have a clubhouse with a director and this adds much to the educational and social life of the community, since employees have their choice of interesting recreational and social activities.

The medical department employs four women physicians, one being a psychiatrist, and they care for the health of the employees as well as that of faculty and students.

All employees have a physical examination at the time of employment and again at the beginning of the school year in September. Food handlers are again examined in February.

Male employees were formerly requested to go to their own physicians for examination, but now they are seen by a town doctor selected by the college authorities, which makes all examinations uniform. Female employees are examined by the staff physicians at the college. Adequate records are kept and supervised by the nurse.

Food handlers and dairymen have nose, throat, and stool cultures and routine Wassermann tests with each examination. All employees are vaccinated at the time of employment unless they have been vaccinated within three years.

Recommendations made by the physician are closely followed by the nurse and, so far, splendid coöperation and good results have been obtained from the employees. The principal corrections have been on teeth, tonsils, eyes, feet, blood pressure, nutrition, and mental health. The special diet list is a long one and includes overweights, underweights, diabetics, cholecystitis victims, and a rather large number of those with abnormal blood pressure.

The nurse has two infirmaries, one at either end of the campus, each with two beds. Employees who are ill and live on the campus are admitted and cared for by the staff doctors and nurse. If they are very ill, they are sent to a hospital. Those who live at home are visited by the nurse and necessary care given on the first visit, at which time the family is instructed in the care or a nurse from the local nursing association is called. Sometimes, families have special nurses. Patients at home have their own physicians in attendance, but

they are required to report at the medical department at the college before they return to duty. Sometimes we have "prenatals" to add to the interest. Employees are not asked to leave when they marry except in case of pregnancy. In a community of this size, it is not surprising to find employees marrying within the group.

If at time of illness, an employee requests his own doctor, he is allowed this privilege. In case of questionable diagnosis at any time the physician in charge at the college always calls in a consultant from the city.

The advent of the nurse brought about a rather undecided state of affairs in the minds of the employees, especially those who lived "off campus"—they regarded the system as one of espionage, but that feeling has been completely broken down and replaced by one of confidence in anticipation of the nurse's visit.

Routine hygiene classes are conducted by the nurse and these have brought excellent results (inasmuch as early symptoms are recognized and reported) not only in physical health but also in mental well-being. Accidents, no matter how trivial, are now reported promptly and this was no easy point to "get over."

Occasionally, the nurse meets the men in their various departments for ten-minute health talks; she often has a meal with the employees in their halls, thus getting a closer contact with each one, and one evening a month is set aside in the clubhouse at which time the nurse conducts an open meeting and discussion on health. Many interesting and important points are brought up at these meetings.

The nurse's day on duty is somewhat longer than that of the average public health nurse, but this is compensated by periodic vacations when college closes. The working week is six and a half days with a weekend off duty once a month. The nurse has a very bright office in the Medical Building (the old "Gym.")—decorated in modernistic style and employees report there and are given all the attention shown the faculty and students.

The social life at the college is not a dull one for the nurse; she can attend evening lectures, plays, recitals, and any number of "doings" which go to make college life. Since there are nine hundred acres of college grounds, there is ample room for hiking and in winter, skiing, skating, and tobogganning.

The college is only two miles from Poughkeepsie and the various agencies in that city have given unlimited coöperation to the new nurse in their midst.

OUR CONTRIBUTORS

MISS OLIVE A. COLTON, who speaks so frankly to board members (page 181) is Honorary President of the Toledo (Ohio) League of Women Voters, Vice-President of the Toledo Consumers' League, Treasurer of the Ohio Bureau of Women's Work, Trustee of the Foreign Policy Association, member of the Council on the Cause and Cure of War, and former Trustee of the District Nurse Association. *Scribner's*, the *Survey*, and *Outlook* have published her articles. ¶ MARY M. RICHARDSON is a graduate of St. Luke's Hospital Training School for Nurses, New York, N. Y.; B.S., Teachers College Columbia University. Her public health experience includes work with the Henry Street Visiting Nurse Service, and the Providence District Nursing Association. She has had a course in midwifery at the British Hospital for Mothers and Babies, Woolwich, London, and holds a certificate from the Central Midwives' Board. For three years she was Directress of Nurses at Manhattan Maternity Hospital in New York. She is now Assistant Director of the Providence District Nursing Association, Rhode Island. ¶ ELIZABETH HALL is a graduate of the Rhode Island Hospital in Providence. She had her postgraduate work in Public Health Nursing at Simmons College, Boston, and was for five and a half years on the staff of the Community Health Association in Boston, after which she accepted the responsibility for organizing a public health department for the employees of Vassar College—her present job. ¶ MARY EMMA SMITH, page 194, is Director of Nursing Activities of the National Society for the Prevention of Blindness. ¶ KATHERINE OSTOICS is a graduate of the Red Cross School for Nurses in Budapest and is the county public health nurse, Zemplin, Hungary.

SUMMER SCHOOLS AND INSTITUTES OPEN TO PUBLIC HEALTH NURSES—SUMMER OF 1934

The following schools and universities which offer a year's course in public health nursing meeting the minimum requirements of the National Organization for Public Health Nursing are announcing summer sessions. For students meeting the admission requirements this work may be counted toward a certificate or degree.

University of California.

Berkeley, Calif. June 25-August 3. Courses in Educational Psychology, Growth and Development of Children. Miss Elnora Thomson, Guest Instructor, will teach Principles of Public Health Nursing and History of Nursing.

Los Angeles, Calif. June 29-August 10. Courses in Public Health, Principles of Teaching, Principles of Public Health Nursing. Mrs. Helen D. Halvorsen, Instructor.

For further information write to Dean of the Summer Sessions.

University of Michigan, Ann Arbor, Mich. June 25-August 4. Courses in Hygiene, Public Health, Principles of Public Health Nursing, Nutrition.

For further information write to Mrs. Barbara Bartlett, Professor, Public Health Nursing.

University of Minnesota, Minneapolis, Minn. First term, June 18-July 28. Second term, July 30-September 1. Courses in Preventive Medicine, Maternal and Child Hygiene, Mental Hygiene, Health of the School Child, Tuberculosis, Principles of Public Health Nursing, Social Case Work including urban and rural and public welfare administration. Limited field practice in public health nursing.

For further information write to Miss Eula B. Butzerin, Director, Public Health Nursing.

Washington University, St. Louis, Mo. June 15-July 27. Courses in Psychology, Sociology, Family Health, Principles of Public Health Nursing, Methods in Health Teaching.

For further information write to Miss Anna Heisler, Professor of Public Health Nursing.

Columbia University, Teachers College, New York City. July 9-August 17. Courses in Principles of Public Health Nursing, Teaching in Public Health Nursing, Supervision in Public Health Nursing, School Nursing including field experience, and other courses in allied departments.

For further information write to Prof. Isabel Stewart, Director, Department of Nursing Education.

Syracuse University, Syracuse, New York. July 2-August 10. Courses in Public Health Nursing, and Teacher Training Course for Home Hygiene Instructors in coöperation with American Red Cross.

For further information write to Miss Ellen L. Buell, Director, Department of Public Health Nursing.

Western Reserve University, Cleveland, Ohio. June 25-August 4. Regular Courses in Public Health Nursing and others related to professional field.

For further information write to Miss Anna L. Jenkins, Assistant Director, Public Health Nursing, School of Applied Social Sciences.

George Peabody College for Teachers, Nashville, Tenn. Two terms six weeks each, first commencing June 11, second July 19. Courses in Public Health Nursing, Health Education, and allied subjects.

For further information write to Miss Aurelia B. Potts, Director of Nursing Education.

University of Washington, Seattle, Wash. First term, June 20-July 27. Second term, July 30-August 30. Courses in Public Health Nursing, Nutrition, Sociology, and allied subjects.

For further information write to Mrs. Elizabeth S. Soule, Director, Department of Public Health Nursing.

(Continued on next page following)

Some of these summer courses may be of interest to Civil Works nurses since they are designed for new public health nurses.

SUMMER SCHOOLS AND INSTITUTES (Continued)

OTHER COURSES OF INTEREST TO PUBLIC HEALTH NURSES

American National Red Cross Teacher Training Courses for Instructors in Home Hygiene and Care of the Sick. In coöperation with:

University of California, Los Angeles, Cal. (For nurses in the Pacific Area)	June 29-Aug. 10
Pennsylvania State College, State College, Pa.	July 2-Aug. 10
Syracuse University, Syracuse, New York	July 2-Aug. 10
Colorado Agricultural College, Fort Collins, Colorado	July 8-Aug. 17

For further information, write to Miss I. Malinde Havey, National Director Public Health Nursing and Home Hygiene, American Red Cross, Washington, D. C., or to the Branch Offices in St. Louis or San Francisco.

Colorado State Teachers College, Greeley, Colo. First half, June 16-July 21. Second half, July 23-August 24. Courses in Nursing Education including Survey of Nursing Problems with Prof. Annie W. Goodrich as Guest Instructor.
For further information write to John Henry Shaw, Director, Department of Publications.

University of Chicago, Chicago, Ill. Will offer several courses of interest to nurses.
For further information write to Registrar, University of Chicago.

Connecticut State Board of Education conducts a Teachers College Summer Session at Yale University, New Haven, Conn. July 2-August 10. Courses in Health Education, Home Hygiene, First Aid and Safety Education, Personality Problems in School Children.
For further information write to Franklin E. Pierce, Director, Division of Teacher Preparation, State Board of Education, Hartford.

Harvard Medical School, Boston, Mass. June 21-August 4. Offers a course in Physiotherapy. Nurses applying must have had special course in anatomy in addition to undergraduate training as well as experience in giving therapeutic exercises and massage.
For further information write to Assistant Dean, Courses for Graduates, Harvard Medical School, Boston.

Massachusetts Institute of Technology, Cambridge, Mass. July 5-August 10. Offers a course in Bacteriology.
For further information write to B. E. Proctor, Department of Biology and Public Health.

Cornell University, Ithaca, New York. July 9-August 17. Courses in School Health Supervision, Hygiene of the School Child, Home and Community Hygiene.
For further information write to Prof. R. H. Jordan, Director of Summer Sessions.

College of Physicians and Surgeons, Columbia University, New York City. June 11-29. Course in School Health Supervision for physicians and experienced school nurses.
For further information write to DeLamar Institute of Public Health, 632 West 168th Street, New York City.

New York University, New York City. July 9-August 17. Courses in Child Hygiene, School Nursing, Health Teaching.
For further information write to Milton E. Loomis, Assistant Dean, School of Education.

New York School of Social Work, 105 East 22nd Street, New York City. First term, June 20-July 25. Second term, July 26-August 31. Courses in Social Case Work, Community Organization, Public Welfare Problems. Nurses must meet regular admission requirements.
For further information write to Registrar.

Pennsylvania State College, State College, Penna. July 2-August 10. Courses in Principles of Teaching, Home Hygiene, and Health Education.
For further information write to Director of Summer Session.

FOREIGN STUDY FOR TEACHERS

International Institute of Teachers College, Columbia University, New York, is offering to teachers a number of field courses in the study of European education during the summer of 1934. Separate groups will visit Germany, France, or England to study at first hand the educational system of that country, as well as to contact other phases of its life and culture. University credit will be granted to those completing the requirements. Address all inquiries to Dr. Thomas Alexander, International Institute, Teachers College, Columbia University, New York City.

County Health Work in Zemplin-Hungary

By KATHERINE OSTOICS, R.N.

OUR county, Zemplin, lends itself as a special territory to all kinds of public health work, being one of those which, mutilated through the Treaty of Versailles, fell victim to the atrocity of new conditions.

The chief town of this ailing county, Sátoráljáujhely, is showing up as "pars pro toto" all the social and moral misery that was to follow. Having been the center of trade and traffic for a region of 400,000 inhabitants, it has now lost two-thirds of its market. Slow death of this town seems unavoidable. Hopelessness of their situation cast a dark shadow over the morale and physical health of the people, and from a well-to-do, work-loving existence, one-fifth have come down to pauperism—a tramping, work-hunting life, full of bitterness towards the upper classes "who have stopped caring."

And these upper classes? Owners of the famous Tokaj-Hegyalja vineyards for generations—those unique vines known all over the world—they are now unable to cover even the cost of their production. In consequence of the war and post-war conditions and earlier historical reasons, export ceased and the "vine of vines" is stored year after year hopelessly to the ruin of its producers. With this class of people, appearance of social standard is kept up, but it is only the low and simple who cannot peep over their screen of social self-respect to see wrecked fortune behind it.

Such is the atmosphere in which public health work was to be started when, in March, 1928, I was appointed county health nurse and something of a social worker, by his honor the County Chief, Mr. Szell, with the program to organize and develop public health work in Zemplin and take social case work as well, if required.

STARTING HEALTH WORK

My appointment was due to a friendly interview of Mr. Szell and Mme. Ibranyi, General Matron of the Red Cross Nursing Service, who, deeply impressed with Zemplin as a battlefield for health work and aware of my pending arrival from America, seems to have been accountable for suggesting it.

We hoped to have the system of Red Cross county nurses generalized all over Hungary. However, excepting "Abanj," another county under Mr. Szell's administration, no other county has followed suit.

At that time existing health organizations at Sátoráljáujhely were the Stefania National Association for maternity and infant welfare work and an antituberculosis service of a rather primitive type, lacking funds and trained workers. Both are subsidized by the State.

Outside of these the county chief medical officer and his provincial aids are supposed to solve health problems, keep up and improve sanitary conditions according to traditions of health administration in Hungary. No consideration can be given at this critical stage to housing and sewage and I was struck to the quick on seeing those damp and dark rooms and cellars which here are still inhabited by the poor.

SCHOOL CHILDREN FIRST

Under this vivid impression, for the sake of those pale-faced children that hover like sickly plants grown without sunshine in the damp and mouldy air of cellars, the decision was made to take up school work at first, though I had an idea it was not health rules these children wanted most badly.

At a meeting at the County Hall, under Mr. Szell's chairmanship, all the medical men, headmasters and chief officials of the town and county were present and I succeeded in convincing the respective minds of the necessity of school health work. We all agreed on a town organization which would be made the center for the county later.

With a generous offering of funds by county, town, and hospital, my work started under the authority of the chief medical officer, who neither approved of nor objected to it, leaving me free action and very much unsupported! Having no appointed school doctor, some medical men offered their services unselfishly and after six weeks' hard work 1,800 children were examined, weighed, measured, their sight and hearing tested, and records taken.

Records for six elementary schools, each of six classes, with social and health data of each child under my care, were at my disposal and seemed like the foundation of a beautifully conceived new building.

Our system was impetuous and unusual but there had been no time to go in for routine and calmness. At any rate it had the effect of all things noisy and quick: the news went like wild-fire among parents that there was something to be expected for the benefit of their children's health, and I was glad to see how the belief in the need of child welfare work became in no time public opinion.

Holidays were used to make calls and get acquainted with parents and homes. After a few experiments with an individual system, the cautious style of intercourse was adopted which I saw and ridiculed as a waste of time in America. People even in our humble Zemplin hated to be shown their ignorance openly and preferred those bitter pills in sweet coating which I knew to be administered by American public health nurses.

At the beginning of the new school year a school doctor was employed and examinations were taken up in a more systematic way. A work more likely to have deserved the lovely "Children's Welfare Center" was established that very winter in a spare room of the ancient County Hall where four specialists diagnosed and treated school children with special ailments and diseases.

The doctors by and by became quite enthusiastic about school work. Ringworm for instance, which had been endemic, was actually stamped out by our dermatologist.

At the end of this year school dentistry was given us "ready made" by the Institute of Hygiene with a dentist and assistant paid, but, after half a year, support was withdrawn and we managed to keep it up with our own health funds.

SOCIAL CASE WORK ADDED

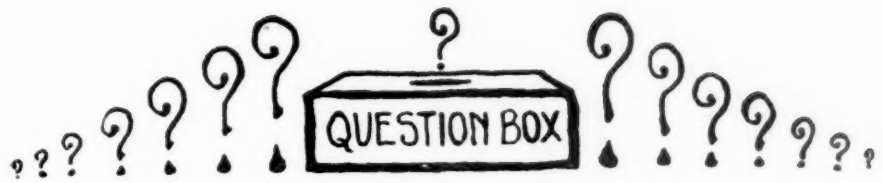
Three years passed in intensive public health work when social conditions turned from bad to worse and it was no longer possible to put off the organization of a social aid system. Due to the energetic County Chief we soon had it going and I was induced to take up social case work in addition.

Remembering the Bedford College Creed that no public health nurse can turn to social work without serious damage to her professional success, I saw with horror how people began to neglect the health worker in me. They came in flocks for everything which was being distributed: shoes, clothes, free lunches for the children, with a keenness which I never noticed concerning health matters. However, I tried to make the best of their error and used my power in getting children to adopt improved cleanliness and health habits to match new clothes—which after all were a safeguard to health too!

Somewhat discouraged, I used to rejoice at very little then, and had the humblest of satisfaction in such discoveries as some of the children using toothbrushes upon my advice with an ambition which the first toothbrush is apt to give, and from the little girl rushing up to me in the street very proudly, calling: "No more nits, Sister! Mother removed them all and now I am going to keep clean."

One of my great joys was the organization of the Children's Outpatient Department in the County Hospital after a four years' desperate struggle for it.

My dream was of course to broadcast hygiene and organize school health work in the whole county and is still far from being realized. No hope of a motor car, no hope of an assistant now.



QUESTION:

If a public health nurse can make only two home visits to babies between one month and one year of age, when should she try to schedule her visits and what questions would she ask the mother?

ANSWER:

[To answer this question practically and out of the actual experience of field nurses, we wrote to several. Their answers are given here.]

From Miriam A. Dailey, Pulaski County Chapter, American Red Cross, Pulaski, Virginia.

Infant welfare conferences conducted at regular intervals by the nurse working in a rural district furnish the quickest and best means of dispensing information to the mothers and of checking up on the condition of the babies, and yet, no conference can be wholly a success unless the nurse has visited each home and knows existing conditions there.

In answering this question, I should be guided by two or three possible factors, namely: the degree of intelligence of the mother; whether or not the mother is attending the infant welfare conference regularly; and whether the baby is breast or bottle fed. Assuming that the majority of mothers in a community are of about average intelligence, are taking advantage of the conferences, and have breast fed babies, I should try to schedule a home visit between the third and fourth month and again about the ninth month. (The initial visit should be made much earlier if the baby is bottle fed.)

When the first visit is made in the home a number of items of information, which have not previously been reported, can, in all probability, be gleaned by observation rather than by questions: such as whether or not the house is screened; the method of sewage disposal; the sanitary condition of the home; the proximity of stables or other outhouses to the water supply; means of ventilation; and amount of sunshine obtainable in the home. Discussing these items with the mother, will focus her attention upon them and emphasize their importance. Direct questioning, or friendly conversation, will elicit information as to the type and actual amount of work the mother must do, and the opportunities she has for rest; her mental attitude; and her ability to regulate the affairs of her household. Then, of course, come the questions regarding the physical condition of the mother, with advice and suggestions as to elimination, diet, sleep and rest, and recreation. She should have learned, from the conferences at the welfare station, how much the baby's health depends upon her own good physical condition. A general check-up can then be made on the baby with questions regarding bathing, proper amount of clothing and method of laundering, regular habits, amount of cod liver oil and orange or tomato juice given, and suggestions made for further care. Keeping in mind the fact that another visit will not be made for several months, it might be well in some cases to demonstrate to the mother the use of a double boiler (which may have to be improvised) in cooking cereals when the baby is old enough to have them, and the simplest method of preparing puréed vegetables when the time comes to add them to the diet.

Assuming that the mother continues to attend the conferences at the welfare station where the baby's weight and general development can be checked, she will be advised when to begin feeding solid food and when to start weaning. But, as the tendency among rural mothers is to nurse their babies considerably over a year, the second visit should be scheduled when the baby is between nine and ten months of age, in order to be sure that the mother carries out instructions for weaning. She may be questioned as to the baby's diet, the safety of the milk supply, the amount of exercise, sleep, and sunshine she includes in the baby's daily schedule, and the progress she has made in training for regular habits. Immunization against diphtheria should have been completed.

In limiting the supervision to two visits one grave danger presents itself. So much information must be crowded into each visit that the mother may become completely swamped with ideas, and unless two or three vital points are selected and thoroughly emphasized, she may forget much of what has been said. If she attends the conferences regularly, however, the important items can be kept in mind.

From Anne Poore, R.N., Infant Welfare Society of Minneapolis, Minn.

No two infant welfare visits are alike. Each baby must be considered individually. Therefore, the writer has confined herself to a general outline and assumes that the baby in question

is normal, the mother married, the birth registered, the family's food and shelter provided for, and the baby not under medical care.

When a baby clinic is available:

The first home visit would be made as soon as possible. Observation, demonstration, and directed conversation would cover the following:

The value and technique of proper feeding
The importance of an emotionally—as well as physically—satisfying suckling experience
The daily regime, bathing, clothing, laundry, sleeping arrangements; regurgitation, vomiting, defecations; eyes, skin, umbilicus, buttocks, genitalia (with proper names of parts and functions)
The importance of regular medical supervision of a well child
The symptoms and prevention of illness, and the importance of early medical attention
The mother's present health (especially diet, rest, and postpartum examination) and the health of other members of the family
An evaluation of the mother's standards and capability
The attitudes of the family toward the baby
Early preparations for personality development
A plan for further contacts

If the baby is taken regularly to a clinic a second home visit might easily be unnecessary. However, at any time during the first year another home visit might be indicated or contra-indicated because of some of the following considerations:

The baby's physical condition
The doctor's orders regarding all aspects of care and training
The mother's apparent dependability, and her acceptance of clinic standards
Other resources available

When no baby clinic is available:

If home visits are to be made upon babies who can not have private medical care and are not within reach of a clinic, the nurse would have clear, conservative standing orders from a responsible medical source and frequent clinical study to maintain her standards. The first home visit would be made as soon as possible and would cover about the same material as though clinics were available. In addition, the nurse would endeavor to give this mother a complete picture of what constitutes normal physical and emotional growth, and how she could best carry this responsibility without adequate guidance, and how to use the medical care available. It would be wise for this mother to have Government bulletins for reference.

The date of a second visit would be determined by many factors, principally

The baby's apparent condition and the mother's need for and interest in the nurse's services (as shown in the first home visit)
Any information regarding the family which might have reached the nurse since the last home visit

If the second home visit is made within a few days, the content would be similar to the first home visit, with concentration chiefly on the problems peculiar to this baby. If the child is seen later the nurse would take up such of the material covered in the first home visit as might seem necessary, and in addition:

The technique of weaning with special regard for the child's emotional experience and the mother's welfare
The nutritional requirements of children, the preparation and introduction of new foods to make them of the highest value
The earliest achievements in self-reliance and their significance
The importance of early immunization

From Belle G. Winston, Child Welfare Association, New Orleans, La.

If we assume that the baby was delivered and examined by a physician; that the baby is a normal child; that illness did not occur during the first six weeks of life, then, in my opinion, the nurse should schedule her first visit as soon as possible after the first month and the second visit when the baby begins to take foods other than milk, probably between the fourth and sixth month. The following questions are suggested:

First Visit at One Month

Does the mother realize that this first year is the most important in the baby's life; that the baby's future mental and physical well being depends in large part upon habits formed during this year? Does she know that she must not take the advice of well meaning neighbors, but rather that of a physician or a nurse? Will she take her baby to a clinic or to her private doctor for regular physical examinations, advice, and weight? Does she realize the importance of regular feeding habits? Does she know that breast milk is the best type of feeding for infants? Does she know the technique of caring for her breast before and after nursing? Does she know that she must not wash the baby's mouth unless a doctor has so ordered? Does she know how long to allow baby to remain at breast; that unless otherwise advised by doctor, only one breast should be given at a nursing; that her position while nursing should be com-

fortable and relaxed? Does she put baby over her shoulder and pat gently after nursing in order to help him belch any air he may have swallowed during nursing and that this may also prevent him from "spitting up"? Does she understand the importance of personal hygiene, proper diet, regular sleep and rest? If baby takes formula, does mother know how to prepare it? Does she know that the baby should not be longer than twenty minutes taking his food and should be held in the same reclining position in the arms while taking formula as when nursing the breast? Does she know that the baby should be returned to his bed after putting him to her shoulder to expel the air bubbles?

Does she offer him boiled water frequently between feedings? Is she giving him cod liver oil, orange juice, or tomato juice regularly if prescribed by a physician? Does she know the color and consistency and odor of a normal bowel elimination, and that drugs should not be given for constipation or diarrhea, unless ordered by doctor? Does she know that it is important to consult a doctor for either of these conditions and that to discontinue feeding until doctor is consulted is the safest thing to do in cases of diarrhea? Does she know how to give a simple enema? Does she watch kidney elimination?

Does she know that the normal baby should have at the same hour every morning a daily bath winter or summer? Does she know the bath technique and the care of the special organs? Does she know how to remove a "milk crust"? Does she know the type of clothes for winter and summer and that the baby should never be too warm in winter, since being too warm is the most frequent cause of colds? Does she put on the square diaper? Does she know that the baby should never stay wet? How does she care for the diapers? Does she know that rubber pants should only be used on special occasions? If stockings or bootees are worn, does she know that they should be pinned to the diaper? Does she know that baby should be put into a nightgown at night; that baby should have his own bed in a well ventilated room? Does she know that the bed clothes should be light, but warm in winter, and that the baby should be cool in summer? Does she know that the baby one month should sleep at least twenty-two hours out of the twenty-four, and should be taught to sleep in spite of ordinary noises?

Does she watch the baby's color and condition of skin, and his weight? Does she give sun baths? Does she know that sucking a pacifier or thumb is an extremely bad habit? Does she know the state of health of all persons in close contact with child and that she had best avoid all contagions or infections? Does she realize that her baby is healthier if allowed to stay in his crib; that he should not be rocked whenever he cries? Does she understand that if she has the coöperation of the baby's father and others in the home that her task is much more simple; that the consistent carrying out of her plan from day to day is the only way in which really to establish habits?

Second Visit (when foods other than milk are first given)

This period is important because at this time the baby, if normal, has become more conscious of his surroundings; has been given a diet in addition to his milk; may have begun cutting teeth; and is being trained in bowel and kidney control. At this time, too, there are many things about the baby that the mother should be taught. Some of the questions at this period would be:

Does the mother know how to prepare cereals, crisp bacon, green vegetables, simple dishes, soups, fruits, and jello? Does she still give orange juice, tomato juice, and cod liver oil? Does she know with what amount of food to start? Does she know that there are a number of conditions for her to watch in order to determine if baby's food is the right sort; such as, bowels, gas or colic, vomiting, restlessness, weight? Does she know that the baby may have to be taught to eat food that is different from what he has been taking; that his vegetables or cereals must be given with the breast or cow's milk and not between feedings; that baby should not be distracted or played with while he is eating; that if he refuses food, he should not be coaxed to eat? Does she know that now that baby sleeps less, that regular sleeping habits must be taught; that he must be put in bed while awake at a certain hour at night with no bottle and no breast; that the lights should be out and he should be left alone? Does she know that the baby should not be rocked to sleep? Does she know that his day naps should be at regular hours?

Has she started training him for bowel and bladder control? Does she know that masturbation may be prevented by focusing the attention on other things? Does she know that his toys should be simple, washable ones and that he should play by himself in his crib or play-pen? Does she know that it will not hurt his back to sit up, nor bow his legs if he tries to stand? Does she know the kind of shoes to get when he begins to walk? Does she know that teething is a normal process which may cause baby to be fretful, but is rarely the cause of serious illness? Does she know that if baby has "fever" during the cutting of a tooth, she should consult a physician? Does she know that the health of the baby's second teeth depends on the care given his first teeth? Does she now how healthy gums should look? Does she know the importance of outdoor life and proper clothing to be worn outdoors? Does she know how to give a sunbath? Does she know the importance of vaccination and immunization?

From Ethel R. Jacobs, Noble County Tuberculosis Association, Albion, Ind.

These visits have been scheduled to be made when the baby is at one and six months of

age. It is assumed that the mother is of average intelligence; that she will return to her family physician for well-baby care; and that she does *not* have access to baby conferences.

Visit No. 1:

General information on the family as a unit should be obtained and recorded for future reference. Inquiry should be made regarding the following conditions:

The family: Is the father living and at home, number of children, attitudes, the health of the mother, does she plan to receive a postpartum examination.

The general health of other members in the household: Are any ill? If so, recommendations are made with the welfare of the baby the first consideration.

The economic status of the family: Will it be necessary for any relief-giving agency to give assistance?

An attempt is made not to give the mother so much information on this first visit that it will prove difficult for her to retain the essential facts. Nevertheless, if the mother is made to understand that from the day of its birth, the baby starts forming habits, and that regularity in routine will make for a happier baby and facilitate the mother's work beyond measure, these visits will have meant a great deal to her.

Now with the preliminaries disposed of, the baby's diet and feeding schedule are studied. Is the baby on breast feeding and making a reasonable gain in weight or do symptoms appear which may be responsible for the diminishing of the milk supply, such as worry, overwork, and inadequate diet? The value of breast feeding is stressed. If a supplementary feeding has already been started or may be probable, full directions on formula-making are given and the mother referred to her own physician for advice on the ingredients to be used. Orange or tomato juice may now be included in the baby's diet, mention being made that the latter is just as beneficial if given in larger amounts and may be more economical. Cod liver oil may be suggested, taking into consideration the attending physician, the nurse's standing orders, and the season of the year. With the establishment of an adequate diet, the mother should expect a reasonable gain in the baby's weight each week.

The next consideration is whether or not the baby is getting enough sleep and rest in a place where fresh air and sunshine are available. Is a comfortable and separate bed provided? The mother is taught there is no season of the year but what the baby could be outside for a period of the day if properly clothed. The clothing should be warm, light in weight, simply made and adapted to the temperature of the day. At this age it is most important that the baby receive the required number of hours of rest.

For some phases of child care, the printed word may serve the best purpose for the mother. Literature is left on food preparation, the best procedure for giving sun baths, training for regular habits of elimination.

Visit No. 2:

The visit made by the nurse at six months of age presents a picture of many physical and mental changes having taken place. Baby has now reached the age when it is possible to obtain protection against diphtheria and small pox. The mother is advised to see her family physician concerning this treatment. Have desirable habits in eating, sleeping, rest, and play been formed? Is there an understanding of new foods to be added to the diet and the best way to prepare and present them? Has the child been allowed to do for himself as much as possible or have other members in the family waited on him too much? Has the mother taken advantage of the fact that eating and playing with the right type of toys affords an excellent opportunity of encouraging exercise and promoting initiative? Suggestions may be given to correct or improve some of the difficulties incurred during these first few months. The termination of this visit will show evidence of the mother's understanding of the fundamentals in caring for her child. Also, whether or not she has made too large or too small a place in her life for this baby.

From Elizabeth Hittle, Infant Welfare Society of Chicago, Ill.

In answering this question, it is assumed that the mother has been given a schedule by her doctor, that this is the first home visit being made since the baby's birth, and that medical supervision by her doctor will be continued during the ensuing year.

Because many future problems can be avoided by the formation of early habits at a very early age, the first home visit would be made as soon as possible—in this case, during the second month. The second visit would be made in the ninth month, because more changes take place at this time.

Inasmuch as the period between these two home visits is of several months' duration, the mother will need specific advice in training and care.

The first question would be regarding the baby's schedule. Correct sleeping habits will be quickly formed if the mother realizes the importance and the simplicity of this procedure. Even with the small infant, who sleeps most of the twenty-four hours, the mother would be advised that he be prepared for the night at the time of the six o'clock feeding, and put to bed immediately following. As the child requires less sleep, the afternoon nap may be shortened but the bedtime remains unchanged.

While discussing sleeping hours, the mother would be asked whether the child is sleeping

alone, and the suggestion made that when possible he sleep in a room by himself in order to lessen dependence on the mother. The necessity for a firm mattress and no pillow, light-weight bedding, and a well-ventilated room would be explained, and advice given against the use of pacifier, bottle or rocking as a means of putting the child to sleep, or soothing him when crying.

After determining whether the baby is breast or bottle fed, or both, the care of the mother's breasts, or the preparation of bottles, would be discussed. The mother may need instruction in lactating measures and will be reassured by the fact that breast milk may be increased by the correct diet, an abundance of water and sufficient rest. If a bottle-fed baby, definite instructions regarding sterilization of equipment and boiling of milk and water will be necessary.

The procedure for training for bowel control would be exp'ained, and the mother advised to begin this training when the baby is two months old.

Need for a daily airing for a short time in all except very severe weather would be explained, and an outdoor nap whenever possible, advised.

Assuming that orders for cod liver oil, orange juice, sun baths, and the method of administering, will be given by her doctor, the mother would be advised to give the cod liver oil from a spoon and the orange juice from a glass, when ordered. In this way, the baby will become familiar with the use of these at an early age. Final advice would be to visit the doctor regularly and to follow his instructions carefully.

By the ninth month, when the second visit is made, the child should be taking all of his water and orange juice from a cup, and his cod liver oil, cereals and vegetables from a spoon. In breast-fed babies, the doctor will probably have begun the weaning process and thus it will be possible for both breast and bottle-fed infants to have one formula feeding daily from a cup. One cup feeding at a time may be undertaken after this until the baby is completely weaned from breast or bottle, which should be accomplished by the end of the first year.

Vegetables should be mashed with a fork at this time, instead of being strained, and the mother should be taught that as the baby gets his teeth, he shou'd have opportunity to use them. As soon as the child learns to chew, vegetables should be served in small pieces and mashing discontinued.

Toilet training for bladder control may be started at this time and training panties should replace the diaper. The mother should be impressed with the fact that the responsibility must rest with her and that the child should not be punished for fai'ures but praised for achievement.

SUMMARY

Summarizing these replies, we find that the two visits to the infant in the first year of life may be very profitably scheduled in the second month and in the seventh. Items of instruction covered in the first visit include feeding, sleep, clothing, regularity of routines and habit formation, bathing, weight, signs of illness and what to do, family's attitude toward baby and in general, the nurse observes the home conditions that affect the baby, the mother's intelligence, leaves literature, and assures herself that the mother knows how to call the nurse, and the importance of medical supervision.

The second visit checks on the first, and adds information on the preparation of the enlarged diet allowed at this age, habits of elimination, immunization, care of the teeth, play and playthings, increased use of muscles (walking, feeding self, etc.), sun baths, mother's mental attitude toward baby and the importance of encouraging independence. Again literature is left and importance of continued medical supervision stressed.

QUESTION: HOW MUCH DOES IT COST TO RUN A CAR?

ANSWER:

The costs of operating a fleet of automobiles by a business concern may not be strictly comparable to the costs of operating the three or four, or possibly one, automobile of a public health nursing agency, but the cost per mile of operating a car as shown by the reports of such commercial companies, does give a basis for judgment as to what might be considered a reasonable cost per mile for operating a car. Some recent published reports on average costs per mile are as follows:

Average cost per mile:

4.035 cents—based on reports of 33 companies, *Printers' Ink*, September, 1933.
4.0 cents—based on reports of 13 companies, *Sales Management*, July, 1933.
3.06 cents—based on report for fleet of Chevrolet cars, *Fleet Users*, September, 1933.

These figures seem to indicate that it would cost a nurse at least 4 cents per mile to operate her car. Making allowance for the fact that the mileage traveled by a nurse would not be so great as that traveled by the automobiles used for computing the figures given, then 5 cents a mile would seem a fair rate to pay a nurse for the use of her car in making visits.

Some agencies may prefer to pay a flat monthly allowance. Taking into consideration present-day prices, it is suggested that a nurse using her car in average service be allowed $20 a month for operating expenses and an additional $12 per month for depreciation on the value of her car. This would make a total monthly allowance of $32.

As the price of a turned-in car purchased in the past has been settled in terms of the year in which it was manufactured, it is possible to figure quite definitely the monthly depreciation costs of a car when it is traded in. For example, we will assume that a car is to be turned in this year after two years of continuous service and a new car purchased. Studies of automobile costs have shown that this is an economical plan to follow, as the costs of replacing tires and parts and other necessary repairs after two years of service tend to be greater than the costs of new cars. The depreciation costs of a car over the two-year period would be the cost of a new car at the present time, less the turned-in value of the car. This difference should be divided by 24 months to give the monthly depreciation.

As the trade-in value of a car two years from now cannot be predicted, agencies will find it to their advantage as well as to the advantage of the nurse not to pay this monthly depreciation each month, but to pay it in a lump sum at the end of two years, when a new car is purchased. To meet the obligation of paying the nurse for depreciation on her car, the nursing agency would, under this plan, set aside each month in a savings account the amount of money necessary to meet such depreciation on all nurse-owned cars.

HONOR ROLL

Agencies Holding 100 Per cent Nurse Membership in the N.O.P.H.N.

CALIFORNIA
**Visiting Nurse Association, San Diego

COLORADO
*Metropolitan Life Insurance Nursing Service, Denver

FLORIDA
**Osceola County Public Health Nursing Service, Kissimee

ILLINOIS
***First District, Illinois State Nurses Association, Chicago
***Visiting Nurse Association, Evanston
***Winnetka Relief and Aid Society, Winnetka

INDIANA
***Public Health Nursing Association, Evansville
**Public Health Nursing Association, Indianapolis

IOWA
**Visiting Nurse Association, Council Bluffs
*Visiting Nurse Association, Marshalltown

LOUISIANA
**Industrial and Visiting Nurse Staff, Standard Oil Company, Baton Rouge

MAINE
***Lewiston-Auburn Chapter, American Red Cross, Lewiston

MASSACHUSETTS
**Visiting Nurse Association, Brockton
***Canton Hospital and Nursing Association, Canton
*Metropolitan Life Insurance Nursing Service, Malden
**Milford, Hopedale, Mendon Instructive District Nursing Association, Milford
*Visiting Nurse Association, Quincy
**West Springfield Neighborhood House Association, West Springfield

MICHIGAN
***Civic League Nursing Service, Bay City

MINNESOTA
*Infant Welfare Society, Minneapolis
***Metropolitan Life Insurance Nursing Service, St. Paul

MONTANA
*Beaverhead County Public Health Organization, Dillon

NEW MEXICO
*Otero County Nursing Service, Alamogordo
**Torrance County Nursing Service, Estancia
**DeBaca County Nursing Service, Fort Sumner
*Lea County Nursing Service, Lovington
**Roosevelt County Nursing Service, Portales
***Socorro County Nursing Service, Socorro

NEW YORK
*Mamaroneck Society for Lending Comforts to the Sick, Mamaroneck
**Visiting Nurse Association, Mt. Vernon
**Village Welfare Society, Port Washington

OHIO
***Metropolitan Life Insurance Nursing Service, Cincinnati
*Visiting Nurse Association, Cincinnati
***Western Reserve University Public Health Nursing District, Cleveland

PENNSYLVANIA
*Latrobe Chapter, American Red Cross, Latrobe

RHODE ISLAND
**Visiting Nurse Association, Bristol
**Visiting Nurse Association, Warren

TENNESSEE
**Williamson County Public Health Department, Franklin

TEXAS
*Brazos County Health Board, Bryan
**Dallas Public Schools, Dallas
***Fort Worth, Tarrant County Tuberculosis Society, Fort Worth

WISCONSIN
*Sheboygan County Health Committee, Plymouth

***100 per cent for three years
**100 per cent for two years
*100 per cent for one year

NOTES *from the* NATIONAL ORGANIZATION FOR PUBLIC HEALTH NURSING, Inc.

Edited by ALMA C. HAUPT

COME TO THE RALLY!

If you want to meet the founders of the N.O.P.H.N., the past presidents, the pioneer nurse in industry, and the first school nurse in this country—

If you want to talk with past and present staff members of the organization—

If you want to express your appreciation to 48 state membership representatives and hear from Miss Mary S. Gardner how these representatives lifted the N.O.P.H.N. membership from 4,000 to 7,000 in the face of the depression—

Come to the Membership Rally at the Biennial—a luncheon, on Thursday, April 26, at 1:00 o'clock in the Hall of Nations, Washington Hotel.

HOUSING AT BIENNIAL CONVENTION

Miss Elsie Berdan, Providence Hospital, Washington, D. C., has been appointed Chairman of the Committee on the Housing of Catholic Sisters. Requests for reservations may be sent to Miss Berdan. Miss Charlotte K. May, Freedman's Hospital, Washington, D. C., will serve as Chairman of the Committee on Care and Housing of Colored Nurses.

The N.O.P.H.N. headquarters are at the Hotel Washington. Our booth and that of the magazine are Nos. 112-113 in the Auditorium. (See page 47 of the advertising section for list of exhibitors.)

IMPORTANT ANNOUNCEMENT

The long-awaited *Survey of Public Health Nursing: Administration and Practice* undertaken by the N.O.P.H.N. under the auspices of the Commonwealth Fund is ready for distribution. As this report is to be discussed at length at the Biennial Convention, we suggest that our readers secure copies as soon as possible.*

In the foreword of this Survey, Dr. Livingston Farrand states:

"Of the general results and recommendations which emerge especial attention and approval should be given to the emphasis which is laid on the necessity of regarding public health nursing as simply one part of a unified community program. The day is past when public health can be treated as a problem independent of economic, social and educational conditions and if that be true of the public health problem in general it is doubly true of any of its specialized aspects.

"Similarly, the difficult problem of coördinating official and private agencies is faced and discussed with full appreciation of the fact that it is the public interest that is paramount and that official responsibility is inevitable. Whatever the future may have in store in the way of official health administration, there will be need of private effort and demonstration for years to come. Encouraging progress is being made in many of our states and cities in the direction of better mutual understanding between official and unofficial groups.

"The same coöperative attitude appears in emphasizing the indispensable rôle of the medical profession and the importance of its participation in the development of a community program.

"Finally, and most important of all the conclusions, is the evidence that the great immediate need is improvement in the preparation of the public health nursing personnel. This is not surprising. This same obstacle to advance has been met among other types of personnel in the public health field. Communities everywhere require an educated public opinion to demand trained personnel and to make provisions for it. This situation is slowly being improved and this survey indicates clearly definite ways to meet the problem more adequately for public health nursing."

An evaluation of this publication will appear in our May number.

*From the Commonwealth Fund, 41 East 57th Street, New York, N. Y., price $2.00.

NATIONAL ORGANIZATION FOR PUBLIC HEALTH NURSING—

	Monday, April 23	Tuesday, April 24
8:00-9:00		A.N.A. House of Delegates
9:15-10:45	N.L.N.E. Opening Business Session	Joint General Session *What Does the Public Expect from Nursing*—Mrs. Franklin D. Roosevelt *How Can the Public Participate in Bringing This About*—Speaker to be announced
11:15-12:45	N.O.P.H.N. Opening Business Meeting Report of N.O.P.H.N. Activities—Katharine Tucker	A.N.A. Private Duty Section A.N.A. Government Nurses' Section A.N.A. Legislative Section A.N.A. Mental Hygiene Section N.O.P.H.N. General Session *New Developments in Public Health*—Surgeon General Hugh S. Cumming *New Developments in Social Work*—Joanna Colcord
Luncheon 1:00-2:15	Luncheon (closed) J.V.S. Advisory Council Luncheon (closed) Board and Committee Members' Section Business Meeting *Lay Participation in a State Program*—Mrs. Arch Trawick	Luncheon (closed) for Staff Nurses Luncheon (closed) for Chairmen of State Lay Sections Luncheon—*Preparation of Monthly Reports for Registration of Social Statistics.* Dr. Emma Winslow presiding, and discussion by Louise M. Tattershall, Children's Bureau
2:30-3:45	A.N.A. Business Session N.L.N.E. Session Conducted by Advisory Council (2:00 P.M.) N.L.N.E. Session Conducted by Instructors' Section (3:00 P.M.) N.O.P.H.N. Round Tables for Board and Committee Members According to Size of Organizations. See page 217	A.N.A. Section Meetings (continued) N.O.P.H.N. General Session *Public Health Nursing Today* (Report of N.O.P.H.N. Survey)—Katharine Tucker *Channels for Improvement:* Schools of Nursing and Postgraduate courses—Katharine Faville Public Health Nursing Agencies—Elizabeth Fox
4:00-5:30	Lay Members Tea	N.O.P.H.N. Round Tables According to Function of the Individual For the Layman *Recommendations from N.O.P.H.N. Survey of Public Health Nursing Agencies*—Mrs. Homer Wickenden For the Nurse Administrator *Program Planning in Relation to Budgets* The Official Agency—Amelia Grant The Non-Official Agency—Ruth Hubbard For the Educational Director and Supervisor *Improving Teaching Content*—Leah Blaisdell *Improving Teaching Ability*—Ruth Gilbert For the Field Nurse *Making a Field Visit More Productive*—Speakers to be announced N.O.P.H.N. Industrial Nurses' Round Table Vision Testing Technique—Mary Emma Smith N.O.P.H.N. Conference of S.O.P.H.N. Presidents (4:30-5:30) Lay Members Tea
Dinner 7:00		
8:00-10:00	Joint Opening Session Addresses by the three National Presidents Greetings from the American Red Cross Award of Saunders Memorial Medal U. S. Marine Band	Joint General Session *The Changing Order of Today as It Affects the Economic World*—David C. Coyle *—As It Affects Community Life*—Speaker to be announced U. S. Army Band

BIENNIAL CONVENTION PROGRAM—Washington, D. C., April 23-27

Wednesday, April 25	Thursday, April 26	Friday, April 27
A.N.A. House of Delegates	A.N.A. House of Delegates	
Joint General Session *Changes in the Field of Education*—Dr. Bess Goodykoontz *The Changing Order and Nursing*—Annie W. Goodrich	Joint General Session *Health Aspects of Social Legislation*—Speaker to be announced *Legislation and the Future of Nursing*—Adda Eldredge	A.N.A. General Session N.L.N.E. Round Tables (9:00-10:30) N.O.P.H.N. Round Tables According to Population Groupings. Subjects and speakers to be announced N.O.P.H.N. Round Table School Nursing Section *Recommendations from the N.O.P.H.N. Survey of Public Health Nursing Agencies as They Relate to the School Nurse*—Hortense Hilbert
A.N.A. General Session N.L.N.E. Session Conducted by the Committee on Subsidiary Workers N.O.P.H.N. General Session Open Forum for Current Problems N.O.P.H.N. General Session—*Immediate Public Health Problems* Reemployment Adjustments and Their Interest to Industrial Nurses—Speaker to be announced Nutrition—Speaker to be announced	A.N.A. General Session N.L.N.E. General Session on State Board Problems N.O.P.H.N. General Session—*Immediate Public Health Problems* Responsibilities for Maternal Care—Dr. George Kosmak The Need for a More Adequate Program of Maternal Care—Dr. Frances Rothert Discussion—Grace Abbott N.O.P.H.N. General Session—*Community Planning* How Can Public Health Nursing Agencies in a Community Be Combined?—Alma C. Haupt	A.N.A. Round Table for State Chairmen of Service Fund Committees A.N.A. and State Revisions Committee Chairmen N.L.N.E. Round Tables (10:30-12:30 P.M.) N.O.P.H.N. Closing Business Session N.O.P.H.N. Board Meeting
Luncheon (closed) School Nursing Section Business Meeting Luncheon (closed) Industrial Nurses' Section Business Meeting Luncheon (closed) Chairmen of Public Health Nursing Sections of S.N.A.'s	Luncheon *Membership Rally* Three-minute talks by past presidents of N.O.P.H.N. and pioneers in field of public health nursing	N.L.N.E. Closing Business Session (1:30 P.M.)
Sightseeing	A.N.A. General Session (2:00-3:30 P.M.) N.L.N.E. Session Conducted by Committee on Education N.O.P.H.N. General Session—*Immediate Problems in Public Health Nursing* Acute Communicable Diseases—Dr. C. E. Waller Is the Public Health Nurse Behavior Conscious—Dr. Esther L. Richards N.O.P.H.N. General Session *Keeping the Public Informed*—Dr. H. E. Kleinschmidt (Publicity clinic) Vision Testing—Mary Emma Smith (2:00-3:45)	A.N.A. Closing Business Session (3:00 P.M.)
	Unveiling of the Jane A. Delano Memorial Committee on Personnel Practices in Official Organizations (Meeting of National and State Committee Members) (closed) (5:30-6:30)	**FOR DETAILS OF BOARD MEMBERS' PROGRAM SEE PAGE 217**
Dinner (closed) Board and Committee Members' Section. Speaker—Mr. Eduard Lindeman Dinner (closed) Council of Course Directors and N.O.P.H.N. Education Committee		
	Joint General Session *The Changing Order and Hospitals*—Speaker to be announced *The Nurse as Interpreter of the Hospital to the Community*—Mrs. August Belmont U. S. Navy Band	

WHO'S WHO ON THE N.O.P.H.N. BALLOT

The biographies of the candidates appearing on the ballot for officers and directors of the N.O.P.H.N. for the biennial period 1934-36 (see March number of this magazine) are printed here for the information of those of our readers who are N.O.P.H.N. members.

Candidates for President: (One to be chosen. second nomination pending.)

Amelia Grant

Graduate of Faxton Hospital School of Nursing, Utica, N. Y.; Postgraduate at Simmons College and the Instructive District Nursing Association, Boston; B.S. and M.A., Teachers College, Columbia University. Positions held: Supervisor of Nurses, Henry Street Visiting Nurse Service, New York City; Instructor, Nursing Education, Teachers College; Assistant Professor, Yale University School of Nursing; Assistant Director, Bellevue-Yorkville Health Demonstration, New York City. Present position: Director, Bureau of Nursing, Department of Health, New York City.

First Vice-President: (One to be chosen.)

Ruth W. Hubbard

Graduate, Columbia University; Army School of Nursing, Washington, D. C. Positions held: Staff Nurse, Visiting Nurse Association of Brooklyn; Head Nurse, Pediatric Clinic, New Haven Dispensary; Instructor, Yale University School of Nursing; Educational Director, New Haven Visiting Nurse Association. Present position: General Director, Visiting Nurse Society, Philadelphia, Pa.

Grace Ross

Graduate, Farrand Training School, Harper Hospital, Detroit; B.S., College of the City of Detroit; Postgraduate work, University of Michigan. Positions held: Supervisor, Harper Hospital; Child Welfare Nurse, Babies' Milk Fund, Detroit; Staff Nurse, Detroit Visiting Nurse Association; Child Welfare Nurse and Child Welfare Supervisor, Detroit Health Department. Present position: Director, Division of Nursing, Detroit Health Department.

Second Vice-President: (One to be chosen.)

Mary D. Carpenter (Mrs. George O., Jr.)

Chairman, Municipal Nurses' Board, Department of Public Welfare, City of St. Louis; Member, Advisory Committee, Public Health Nursing Course, Washington University, St. Louis, Mo.

Anne R. Winslow (Mrs. C.-E. A.)

President, Visiting Nurse Association, New Haven, Conn. Member, Executive Committee of Board Members Organization of Connecticut Public Health Nursing Associations. Member, Committee which prepared Board Members' Manual. Vice-President, N.O.P.H.N., 1932-34.

Treasurer: (One to be chosen. Second nomination pending.)

Michael M. Davis, Ph.D.

Medical Director, The Julius Rosenwald Fund, Chicago, Ill. Treasurer, N.O.P.H.N., 1932-34.

Members of Board—Non-nurse: (Four to be chosen.)

Maude E. Blackstone (Mrs. A. L.)

Member of Personnel Committee, and Program Committee, National Y.W.C.A.; Chairman, Public Health Division, Chairman, Child Welfare Department, Wisconsin Federation of Women's Clubs; Chairman, Waukesha County Health Committee; Dental Department Chairman, Waukesha County Council of Child Welfare; Member of Waukesha City School Board; Chairman of School Welfare; Member of Board of Outdoor Relief; Member of Community Chest Board; Chairman, Playgrounds, City Council; President, Waukesha Week-Day Religious School Council.

Warren F. Draper, M.D.

Graduate, Harvard University, School of Medicine. Positions held: Assistant Surgeon General, U. S. Public Health Service, in charge of States Relations. Present position: State Health Commissioner of Virginia.

Janet Rockwell Levy (Mrs. Austin T.)

Member, Executive Committee, Rhode Island State Organization for Public Health Nursing; President, Burrillville District Nursing Association, Pascoag, R. I.; Member, Board of Bahamas Infant Welfare Association, Nassau, Bahamas.

Katharine B. McKinney (Mrs. Roessle)

Former President, Albany Guild for Public Health Nursing; Director, New York State Organization for Public Health Nursing; Editor, Board Members Page, PUBLIC HEALTH NURSING magazine.

Alfred E. Shipley, M.D.

Graduate, College of Physicians and Surgeons, New York; Dr.P.H., New York University. Secretary, New York City Department of Health; Major, Medical Corps, U.S.A., Division of Infectious Diseases; Industrial Health Consultant; Secretary, Public Health Committee, Kings County Medical Society, Brooklyn, N. Y. At present: Professor of Preventive Medicine and Community Health, Long Island College of Medicine, Deputy Commissioner of Hospitals, New York City.

Lydia B. Stokes (Mrs. S. Emlen)

President, Moorestown Visiting Nurse Association, New Jersey; Vice-President, New Jersey State Organization for Public Health Nursing; Member of various civic committees and worker for Y.W.C.A.

Estella Ford Warner, M.D.

Graduate, Medical School, University of Oregon. Special study of pediatrics in clinics abroad and in this country. Experience

includes medical service among refugee women and children in France and North Russia; director of the Bureau of Child Hygiene, Oregon State Board of Health; Chief of the Medical Staff and Director of the Marion County Child Health Demonstration, Salem, Oregon; Consultant in child hygiene in the United States Public Health Service, and in 1932 commissioned as an officer with the rank of Surgeon, in the regular corps of the U. S. Public Health Service. At present medical officer in charge of the Office of Child Hygiene Investigations.

Margaret H. Watkins (Mrs. James K.)

President, Board of Trustees, Visiting Nurse Association, Detroit, Mich.; Member of Board of Council of Social Agencies; Member of Board of Tau Beta Community House; Member of Advisory Committee for the Junior League; Member of Joint Council on Community Nursing, Detroit.

Members of Board—Nurses: (Four to be chosen)

Katharine Faville

Graduate, Massachusetts General Hospital, Boston, and Simmons College. Positions held: Red Cross County Nurse, Alcona County, Michigan; Supervisor, Nursing Service, Wheeling (W. Va.) Red Cross Chapter; Nursing Field Representative, American Red Cross; Educational Director, Association for Improving the Condition of the Poor, New York City; Instructor, Nursing Education Department, Teachers College, Columbia University; Director, Department of Nursing, College of the City of Detroit. Present position: Associate Dean, School of Nursing, Western Reserve University, Cleveland, Ohio.

Netta Ford

Graduate, St. Timothy's Memorial Hospital, Roxborough, Philadelphia, Pa. Public Health Nursing Course, Teachers College, Columbia University; Study of Public Health Nursing and Nursing Education in England and European Countries, 1927-28; Past President, Pennsylvania Organization for Public Health Nursing; President, Pennsylvania State Board of Nurse Examiners; Chairman, Legislative Section, American Nurses' Association. Present position: Director, Visiting Nurse Association, York, Pa.

Mrs. Anne L. Hansen

Graduate, Children's Hospital Training School for Nurses, Buffalo, N. Y. Positions held: Staff Nurse, Buffalo District Nursing Association; Director and organizer of Domestic Education for the North American Civil League for Immigrants; District Secretary, Buffalo Charity Organization Society. Present position: Director, Visiting Nursing Association, Buffalo, New York.

Lily Carey Jones

Graduate, University Hospital, University of Virginia. Public Health Nursing Course, Teachers College, Columbia University. Positions held: Staff Nurse, Instructive Visiting Nurse Association, Richmond, Va.; Army Nurse, U. S. Army Nurse Corps; County Nurse, American Red Cross Chapter, Albemarle County, Va.; Tuberculosis Nursing, State Board of Health, Virginia; Staff Nurse, Assistant Supervisor, Supervisor, Henry Street Visiting Nurse Service, New York, N. Y. Present position: Territorial Supervisor for Southern Area, Metropolitan Life Insurance Company.

Sophie C. Nelson

Graduate, Waltham Training School for Nurses, Waltham, Mass. Positions held: Infant Welfare Nurse, Board of Health, Cambridge, Mass.; Overseas, American Red Cross; Chief Nurse, Children's Bureau, Lyons Area; Superintendent, Public Health Nursing Association, Louisville, Kentucky; American Red Cross Field Supervisor for Nursing Service in Central Europe and the Balkans for Relief Program; Director of Nursing, Boston Health League; Superintendent, Visiting Nurse Association, St. Louis, Mo. Present position: Director, Visiting Nurse Service, John Hancock Mutual Life Insurance Company, Boston, Mass.

Olivia T. Peterson

Graduate, St. Paul Hospital, Minnesota. Positions held: Overseas service; Rural Nurse, Minnesota; Demonstration Nurse, Minnesota Public Health Association; Field Nursing Representative, American Red Cross. Present position: Superintendent of Public Health Nursing, Division of Child Hygiene, Minnesota Department of Health, and President of the Minnesota State Registered Nurses' Association.

Marion W. Sheahan

Graduate, St. Peter's Hospital, Albany, N. Y. Positions held: Child Welfare Nurse, Cohoes-Albany, N. Y.; Henry Street Visiting Nurse Service, New York City; City Nurse, Bureau of Health, Albany, N. Y.; County Nurse (Tuberculosis), Niagara County, N. Y.; Supervising Nurse of Tuberculosis, State Department of Health; Assistant Director, Division of Public Health Nursing, State Department of Health, N. Y. Present position: Director, Division of Public Health Nursing, State Department of Health, N. Y.

Agnes G. Talcott

Graduate, Illinois Training School for Nurses, Chicago; Extension classes, School of Civics and Philanthropy, Chicago. Positions held: Head nurse, Cook County Hospital, Chicago; Staff Nurse, Department of Health, Chicago; Assistant Director, Social Service Department, Cook County Hospital, Chicago. Present position: Director of Nurses, Department of Health, City of Los Angeles, California.

Nominating Committee (1936): (Three to be chosen)

Marion G. Crowe

Graduate, St. Elizabeth's Hospital, Brighton, Mass.; Simmons College; University of Ore-

gon; B.S., University of California. Positions held: Industrial Nurse, Magrane Houston Co., Boston; Staff Nurse, Boston Community Health Association; Supervisor, Household Nursing Association, Boston; Tuberculosis Supervisor, Health Bureau, Portland, Oregon; Supervisor of Field Work, University of Oregon. Present position: Superintendent, Visiting Nurse Association, Portland, Oregon; President, State Board of Nurse Examiners.

Anna Heisler

Graduate, Missouri University; Bellevue Hospital School of Nursing, New York; Postgraduate Course, Columbia University, M.A. Positions held: County Nurse, Nodaway and Grundy Counties, Missouri; Child Hygiene Nurse, Missouri State Board of Health; Director, Public Health Nursing Course, William and Mary College, Richmond, Virginia; Staff Associate in Nursing, American Child Health Association. Present position: Professor of Public Health Nursing, Washington University, St. Louis, Missouri.

Ruth Houlton

Graduate, Ancker Hospital, St. Paul, Minn. Positions held: School Nurse, Minnesota Public Health Association; Staff Nurse, Minnesota Public Health Association; Staff Nurse, Washington (D. C.) Diet Kitchen Association; Field Nursing Representative, Central Division American Red Cross; Superintendent Public Health Nursing, Minnesota State Board of Health. Present position: Director, Minneapolis Visiting Nurse Association.

Pearl McIver

Graduate, State Teachers College, Mayville, North Dakota, and University of Minnesota School of Nursing, B.S.; M.A., Teachers College, Columbia University. Positions held: Out-Patient Obstetrical Nurse, University of Minnesota Medical School Clinic; Campus Visiting Nurse, University of Minnesota Student's Health Service; Child Hygiene Field Nurse, United States Public Health Service; Director of Public Health Nursing, Missouri State Board of Health; Special Nurse on Studies of Public Health Administration, United States Public Health Service. Present position: Special Consultant in Public Health Nursing, United States Public Health Service.

Donna Pearce

Graduate, School of Nursing, Hospitals of Graduate School of Medicine, University of Pennsylvania. Positions held: Teacher, elementary public and private schools, Tennessee; Instructor of Nurses, Montgomery Hospital, Norristown, Pennsylvania; field nurse, Blount County Health Unit, Maryville, Tennessee. Present position: State Supervising Nurse, Department of Health, Tennessee.

THE ISABEL HAMPTON ROBB SCHOLARSHIPS FOR 1934-1935

The Isabel Hampton Robb Memorial Fund Committee announces that scholarships and loans are available to graduate nurses wishing to prepare for educational or administrative work in schools of nursing or in public health.

Six scholarships of $300 each are offered for the year 1934-1935.

Eligibility—To be eligible for a scholarship, a candidate should be a high school graduate, able to meet college entrance requirements, a registered nurse, an active member of the American Nurses' Association, and she should have had one year of experience, after graduation, as an instructor or administrator, in the hospital or public health field.

Scholarships are not given for summer courses.

Date of Award—The lists close on May 1, 1934. All applications should be in the hands of the Secretary of the Committee by April 15, in order that histories may be written and credentials secured and copied.

The scholarships are competitive. The six who stand highest, from all who apply, will be granted the scholarships. The next six are considered alternates.

LOANS

Loans from the McIsaac Loan Fund may be made at any time of year, for five years, at 2 per cent interest. A $200 loan is given for an eight-months course; a loan of $100 is given for a shorter course.

Application blanks and information regarding either scholarships or loans may be obtained from the Secretary, Katharine DeWitt, R.N., 18 Worrall Avenue, Poughkeepsie, N. Y.

BOARD MEMBERS PAGE

BIENNIAL CONVENTION BOARD MEMBERS' PROGRAM*

MONDAY

1:00 P.M. Board and Committee Members' Luncheon (business session).
Presiding, Mrs. C.-E. A. Winslow, Chairman, N.O.P.H.N. Board and Committee Members' Section.
Greeting, Mrs. Whitman Cross, Honorary President, I.V.N.A., Washington, D.C.
Secretary's report, Evelyn Davis, Assistant Director, N.O.P.H.N.
Report of Nominating Committee, Miss Gertrude Peabody, Cambridge, Mass.
Talk—Lay Participation in a State Public Health Program—Mrs. Arch Trawick, State Department of Health, Nashville, Tennessee.

3:30-5:00 P.M.
Round Tables

Session I. For Board members of organizations employing one nurse.
Presiding, Mrs. Olney Powers, Virginia.**

Session II. For Board members of organizations employing two to ten nurses.
Presiding, Mrs. L. G. Robbins, President, Pittsfield (V.N.A.), Mass.**
Talks on
Organization of the Junior Board—Neenah, Wisconsin.**
Education of the Board Member—Mrs. Alfred Hammer, Branford, Conn.
A Publicity Program—Mrs. Francis Stokes, Moorestown, N. J., V.N.A.

Session III. For Board Members of organizations employing over ten nurses.
Presiding, Mrs. Gammell Cross, Chairman Nursing Committee, Providence, R. I.
Talks on
Volunteers—Mrs. C.-E. A. Winslow, President, New Haven, Connecticut, V.N.A.
Junior Board—Minneapolis V.N.A., Minn.**
Amalgamated Service—Mrs. Arthur Gordon, Savannah, Georgia.**
Advisory Committee for Official Agencies—Mrs. George Carpenter, Jr., Chairman, Municipal Nursing Committee, St. Louis, Mo.

Tea—I.V.N.A. Headquarters, Washington, D. C.

TUESDAY

4:00 P.M. *Round Table*
Presiding, Mrs. J. Howland Chase, President, Washington, D. C., I.V.N.S.**
Recommendations in Survey That Affect the Board Member.
Speaker, Mrs. Homer Wickenden, Eastchester, N. Y., Public Health Nursing Organization.

Tea—I.V.N.A. Headquarters, Washington, D. C.

WEDNESDAY

7:00 P.M. *Dinner,* Mayflower Hotel.
Presiding, Mrs. Whitman Cross, Honorary President, I.V.N.A., Washington, D. C.
Greetings, Miss Sophie C. Nelson, President N.O.P.H.N.
Speaker, Mr. Eduard Lindeman: Community Responsibility for Health

*For complete N.O.P.H.N. Program see page 212.
**Invited as speakers.

We know you have special problems that you will want to hear discussed at the Biennial, so won't you please send your questions at once to the Board Members' Program Committee at the N.O.P.H.N. We want to be sure there is a chance for you to secure the information and help you need.

SCHOOL  HEALTH

THE NURSE AND THE COMMUNITY

Every school nursing program that is soundly organized bears a definite working relationship to the other health and welfare activities in the community; and every school nurse who is "on the job" is allocating a definite part of her time and service to perfecting these working relationships.

I. Relationship to medical and dental professions, both organized groups and the private practitioner.

This includes the observance of ethical relationships and the securing of standing orders for the nurse's work, satisfactory reporting of cases, willingness to coöperate on home problems, and interpretation to them of the school health program.

II. Relationship to other public health groups. This embodies
   1. A thorough knowledge of the objectives and program of the
      a. Health Department
      b. Of all private agencies doing public health nursing
      c. Such organizations as the Red Cross and tuberculosis groups
      d. The clinics and social service work of the hospital out-patient departments
   2. A definite policy of referring and reporting cases to these groups

III. Relationship to social agencies in the community. This calls for
   1. Membership in a Community Council (if one exists)
   2. An understanding of the aims and programs of such groups as the family welfare agency, the public welfare department, and other case-working and relief agencies.
   3. Coöperation in working on common problems, including a written policy for referral of cases, reporting back, etc.
   4. Active participation in the work of the central index or confidential exchange, by clearing families that present social problems and with whom other agencies are working.

IV. Relationship to organized civic groups who support or participate in health work. For example
   1. Coöperating with special committees of women's clubs, luncheon clubs, etc., on special health projects involving the school child.
   2. Speaking before such groups on school health program
   3. Interesting them in giving financial aid for correction of defects.

V. Relationship to lay groups and individuals and the community at large. This may be strengthened by
   1. The organization of a lay advisory committee for the school nursing service which meets regularly and which may assist the nurse in developing and interpreting the school nursing program. The health committee of the P.T.A. may serve as a foundation for such an advisory group.
   2. The use of volunteers. They may assist in
      a. The periodic physical examination
      b. Motor service for taking children to physician, dentist, and clinic
      c. Arranging for and managing the school luncheon
      d. Publicity program.

VI. Relationship to professional health and nursing groups in community, such as the district of the State Nurses' Association, etc. This provides
   1. An opportunity for gaining professional advice and improvement in professional equipment
   2. An opportunity to interpret to them the school nursing program.

Added to these more formal relationships are the responsibilities the nurse assumes to make known her service to the community. This can be done by regular publicity in newspapers, county fairs and exhibits, etc.; by public speaking; and service on committees that deal directly with community health work.

Each nurse will need to emphasize some of these relationships more than others, and the value of them to the proper development of her work will depend upon

1. The type of community in which she works, *i. e.,* whether rural or urban, socially-conscious or indifferent, etc.
2. Her ability to see the importance of good community contacts and coöperative work and then to convince her school or health authorities of the value of such relationships.
3. Her power of discrimination in balancing her whole program so that the community will get the proper proportion of her time and no more.

LESSON ASSIGNMENT

List all the contacts you have made with community agencies within the last six months. Analyze them according to the following criteria:

Have these contacts furthered the understanding between the school health department and other community health activities?

Does the community understand the school health program because of your efforts and give it full support and coöperation?

Are you following a definite working policy with the medical and dental profession, collectively and individually?

Do the other health and social agencies refer cases to you or consult you on plans for families in which you are both interested? Do you consult them?

Are you asked to participate actively in case conferences, community council programs?

List potential relationships that might be developed.

The following questions give specific instances illustrating the general policies discussed above:

What do you do if you find a prenatal case in a home where you are calling in regard to a school child?

What do you do if you find a preschool child needing health supervision?

What do you do if you find a suspected case of tuberculosis in the home? To whom do you refer the case? The contact? If the family is referred to another agency for supervision do you have a written policy or agreement in regard to division of responsibility and function in that family? Do you continue to make home visits?

If a child in a family on relief can not come to school because he has no shoes what do you do? Do you supply the shoes or do you contact the relief agency?

If you find school children in a certain family are not getting enough to eat, does the school supply a meal, or do you notify the relief agency?

If the periodic physical examinations reveal a child with a cardiac condition, do you automatically refer the child to the cardiac clinic or do you first refer him to his own physician?

What is your policy when you find a case in the home needing bedside nursing care on a visit basis? Do you refer it to the visiting nurse association? Do you continue to make home visits on that case while the visiting nurse is going in? Do you acquaint the visiting nurse with the school health problem in that home, so that she can reinforce your plan for the school child?

This is the fifth topic in the Study Program for School Nurses which started in the December number. Reprints of each topic are available, free to N.O.P.H.N. members, to others 10 cents.

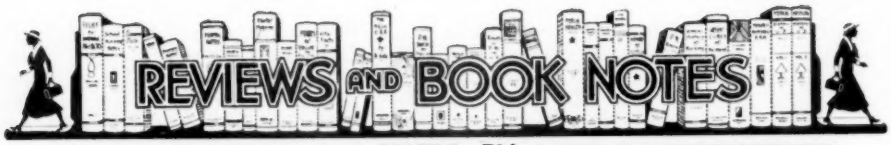
"SEEING OURSELVES"

A wise teacher has found a method in securing interest in clean teeth and neat personal appearance in her morning Health Review, known as "Good Neighbor Club." A mirror in the classroom is hung low enough for the children to pass by and check their own appearance and be their own judge.

The Dental Messenger, Bureau of Dental Hygiene, Iowa.

"Letting people know what is being done to protect their health, why health programs are undertaken and what the people themselves should be doing to protect their health goes under the general head of "public health education." It is one of the most important duties of every local health officer but one often neglected because physicians ordinarily are poor publicists. It is important from the standpoint of the public. There are many things peop'e can do to protect and promote their own health and that of their children. They are entitled to know these things and it is part of the health officer's job to see that they know. It is a good policy from the standpoint of the health officer himself. Taxpayers resent paying for an activity they know little or nothing about. The health officer who lets people know what he is doing for them and why he is doing it—assuming that he is a person of ordinary tact and good personality—can be sure of public support."

Thomas Parran, Jr., M.D.



EDITED BY
DOROTHY J. CARTER

RED MEDICINE: SOCIALIZED HEALTH IN SOVIET RUSSIA

By Sir Arthur Newsholme and John A. Kingsbury. Doubleday, Doran & Company, Garden City, N. Y. Price $2.50.

Red Medicine is an entertaining and well illustrated account of a 9,000 mile trip through Russia, in the summer of 1933, written by Sir Arthur Newsholme, M.D., formerly principal medical officer of the Local Government Board of England and Wales, and John A. Kingsbury, Secretary of the Milbank Memorial Fund of New York City.

Well equipped in practical experience and through the study of medical problems in other countries, they aim to present in this book a description and an appraisal of medical institutions and administration in the only country where health service is organized on a completely socialized basis.

The background of Soviet medicine in Russia's socialized industry, agriculture, education, social and political life is fully discussed. Visits to many hospitals and sanatoria, as well as interviews with many officials are fully reported. Preventive work in the field of infant welfare, tuberculosis, industrial hygiene is fully described. They find that the essential difference between the medical set-up in Russia and other countries is that all Russian hospitals, clinics, etc., are State institutions, and all doctors, nurses, pharmacists, etc., are State officials; all services are provided by government funds, gratuitously to the patient. "Can as good medical work be expected as under the fee system?" they ask, and answer "This is an academic question as far as Russia is concerned. In olden days as now the vast majority could not pay fees, and what they now get is incredibly better than it was, both in quality, in specialist differentiation and in availability."

In the final chapters a comparison is drawn between the medical needs and accomplishments in the United States and in Soviet Russia, followed by a discussion of the advantages and disadvantages of a centrally planned system of State medicine.

In spite of the broad content of this book there are a few additional topics which one could wish had been included. There is, for example, no statement of the costs of a system of socialized medicine, either for the country as a whole, or for an individual city. There is no discussion of the Medical Workers Union, to which belong doctors, nurses, laundresses, chauffeurs and all other personnel connected with Russia's medical institutions; this union has considerable effect on institutional administration and merits study.

There is no analysis of the differences in the curricula of Russian and American medical schools, differences which produce a greater sense of social responsibility in Russian physicians. There is, finally, no account of the place of nurses and of nursing in Russia's medical and preventive health work.

Throughout the book, however, stimulating challenges are offered not only to established medical practices, but to many other traditionally fixed customs in America's social life.

ANNA J. HAINES.

AN ACH INDEX FROM THE A.C.H.A.

A description of the new ACH Index of nutritional status as worked out by the American Child Health Association is now available in pamphlet form. A detailed explanation in regard to taking the measurements of arm, chest, and hips, and calculating the index is given. Price 10 cents from the American Child Health Association, 450 Seventh Ave., New York City.

Diets at Four Levels of Nutritive Content and Cost is the title of a useful

pamphlet recently issued by the Federal Bureau of Home Economics. The four levels are

(1) Restricted diets for emergency use.
(2) Adequate diets at minimum cost.
(3) Adequate diets at moderate cost.
(4) Liberal diets.

In addition to weekly schedules, yearly quantities are worked out particularly for rural workers in assisting farm families to plan their programs of food production for home use. Five cents from the Superintendent of Documents, Washington, D. C.

Health by Radio is the title given to a series of 100 short radio talks on various health subjects by the New York State Department of Health. For ten years the State Health Department has given these talks almost weekly over Station WGY in Schenectady, and health workers will be glad to have this collection of some of them available in book form. The booklet as well as copies of the individual broadcasts may be obtained from the Division of Public Health Education, State Department of Health, Albany, N. Y.

All nine volumes of The Payne Fund Studies on "Motion Pictures and Youth" are now available from The Macmillan Company, New York City.

The Practice of Preventive Medicine by the Private Practitioner, by Iago Galdston, M.D., has been reprinted from the *Health Examiner* and may be procured for 10 cents from Dr. Galdston at the New York Academy of Medicine, 2 East 103d Street, New York. Included in it is an interpretation of the periodic health examination.

A list of fellowships and scholarships in social work for 1934-35 is published in the January number of *The Compass*, monthly bulletin of the American Association of Social Workers, 130 East 22d Street, New York.

A list of reading references on "The Economic Aspects of Medical Care" has been prepared by the Rosenwald Fund and may be obtained from them by writing to the Julius Rosenwald Fund, 4901 Ellis Avenue, Chicago, Ill.

C.W.S. nurses and others working in day nurseries will be interested in the February number of the *Day Nursery Bulletin* which gives suggestions for "Morning Health Inspection in a Day Nursery" and "Isolation in a Day Nursery." Published by the National Federation of Day Nurseries, 122 East 22d Street, New York.

FROM CURRENT PERIODICALS

The aims and objects of ante- and postnatal exercises. Margaret Morris. Mother and Child (London), February. Carefully supervised exercises for both prenatal and postnatal patients contribute not only to the physical well-being of the mother but also to her mental attitude.

The Commonhealth (Massachusetts Department of Public Health) for October-November-December, 1933, devoted to "The Handicapped," presents an excellent summary of the various problems of care and vocational training.

Health department nursing service for urban families. Marion G. Randall. Milbank Memorial Fund Quarterly for January. "Some families require intensive and repeated services because of many and serious health problems, but it is important for the nurse to know how her services are being distributed."

Two-shift employment of women. By Ralph G. Mills, M.D. Industrial Hygiene for January. An analysis of the hygienic and moral questions involved reveals the fact that the two-shift system offers definite advantages over the present plan. See also in the same number, *Caisson work*—a discussion of the predisposing factors to caisson disease, its prevention and treatment.

The outcome of treatment in a child guidance clinic: a comparison and an observation. H. L. Witmer and students. Smith College studies in social work (Northampton, Mass.) "The findings of this paper lend weight to the mental hygiene hypothesis that parent-child relationships are of fundamental importance in determining personality development, and at the same time they suggest that the methods of therapy generally employed are not very successful in remedying the more serious difficulties that arise out of family adjustment."

Prostitution in the United States. Bascom Johnson and Paul M. Kinshie. Journal of Social Hygiene, December, 1933. In the five-year period from 1927-1932 the business of prostitution in the United States has increased in volume and flagrancy. Special efforts are urgently needed to re-educate the public in the fundamentals of the problem.

Our Own Reader's Digest

How Normal Recreation Has Been Adapted for Crippled Children

By HORTENSE L. WILLIAMS

Director of Institutional Recreation, Playground and Recreational Department, City of Los Angeles, California

THE Orthopædic Hospital-School for Physically Handicapped Children in Los Angeles, California, has been very proud to be of service to the Playground and Recreation Department of the City of Los Angeles during the past two years, through coöperation in the adaptation of normal games and sports to the physically handicapped conditions of its hundreds of patients.

Recreation for children, as most workers in the field know, has frequently been of what Jay B. Nash would call the "spectatoritis" variety—in which the child himself had no part.

Standard games and sports have been arranged for the different types of cases, bearing in mind the dangers and advantages from a therapeutic standpoint, yet maintaining the spirit of the original sport and game. Skills, if not the full game, are within the reach of most children. If you can't punt a football down the field with your foot you can with your hand—providing the field is not too large. Volley ball from wheel chairs can be a most exciting game; social recreation, including its usual range of relays, has been delightfully developed for parties. Typical of this general participation is a Hallowe'en Party where the patients come in wheel-chairs; on their gurneys; and even on their beds. Games of skill and chance are so arranged that they can be reached even by children in traction as they are moved from one game to another piling up a score and, finally, selecting from the favor table the awards won. A hilarious and spontaneous party atmosphere cannot fail to develop as these youngsters take their chances and collect their prizes.

POPULAR APPEAL

Probably the part of this work which has not only awakened the greatest public interest but proved both to the children and the spectators that all handicaps can be surmounted and obliterated for the time being, is the field of Dramatics and Pageantry. Three major performances have been produced which have included all types of cases from the ambulatory in leg and back braces, down through the wheel-chair type, and including even those in body plaster casts. The types of production undertaken have been highly imaginative in character rather than realistic —that we might be a Prince or a Princess at least for a day. These plays have been woven together with music to develop body rhythm, poise, and more perfect coördination. The spoken parts have been short, intended to bring out character interpretation and pantomime rather than to permit the child to lean on his lines. The aim has been to develop each member of a large cast instead of depending upon a few leads—all of which requires especially written plays. Costumes have been designed to conceal all evidence of handicaps and to add dignity and grace, as well as color, to help the child in the interpretation of his part.

In "Rhymetta"—a tale of a little Princess who could not dance—there was one scene among the Mermaids in which five sweet child faces peeped above scenic waves, and five pairs of little arms danced dreamily to teach their beloved Princess the part that arms can play in dancing. The "Mermaids" were children in body casts—their handicap completely concealed—joyous in a privilege of participation they had never dreamed possible.

Excerpts from The Crippled Child, October, 1933.

A report of every case of plague, cholera, smallpox or other pestilential disease occurring in any of the principal cities in the Far East is immediately wired to Singapore, where the recently established Eastern Bureau of the Health Organization of the League of Nations relays it on to all neighboring countries. Other activities of the Health Organization during the year 1933 were:

A regional conference in the Union of South Africa to discuss the spread of yellow fever.

Advice to the government of Chile in regard to a study of public nutrition.

Continued coöperation with the National Health Administration of China in carrying out its extensive health program.

Assistance in making a sanitary survey of Slovakia.

✣

Miss Alice G. Carr of Yellow Springs, Ohio, a veteran war nurse and now director of health education work of the American Near East Foundation in Athens, has been awarded a gold medal by the Greek government, in recognition of her eleven years of service for the Greek and other Near Eastern people.

✣

Vancouver (British Columbia) has organized a Health and Welfare Education Group whereby public health and social workers meet every two weeks to discuss new methods and material in the welfare field.

✣

A series of meetings on mental hygiene is being conducted for public health nurses by the New Jersey State Department of Public Instruction and the Bureau of Child Hygiene of the State Department of Health. The first was held in Newark on January 26, the second in Trenton on March 16, and the third will take place in Bridgeton on May 11.

✣

A Division of School Nursing with Margaret J. Barrett of New Haven as Chairman, was formed at the annual meeting of the Public Health Nursing Section of the Connecticut State Nurses Association in Hartford in February. New officers elected were as follows:

Chairman—Irma Reeve, New Haven.
Vice-Chairman—Mary Maher, Norwich.
Secretary—Mrs. Agnes F. Sullivan, Hartford.
Councillors—Marie Wallace, New Canaan; Elizabeth Fox, New Haven; Marion Douglas, Hartford; Elizabeth Stellman, Wallingford; Esther Wells, Putnam.

✣

The campaign against syphilis as a cause of blindness took more active form during the past few months in the passage of resolutions by six Sections of the American Medical Association. Following the passage of these resolutions, the American Social Hygiene Association and the National Society for the Prevention of Blindness adopted as part of their respective programs the promotion of care for expectant syphilitic mothers to conserve sight, and are working out a plan of action.

Since the first course on training medical social eye workers in eye hygiene was given in 1931, eleven medical social eye workers were trained—nine at the Massachusetts Eye and Ear Infirmary, Boston, and two at the Washington University Clinics and Allied Hospitals, St. Louis. Of this number, 10 are actively engaged in some field of prevention of blindness—one as far away as Honolulu, Hawaii, on the "Governor's Committee for the Conservation of Sight." At present, two students are being trained at Washington University Clinics and Allied Hospitals. This is doubtless a growing field for prevention of blindness work.

✣

The following committees of the American Public Health Association have been appointed by the Executive Board:

Committee on Historical Review and Restatement of Objectives of Public Health Nursing Section: Marguerite Wales, New York

City, *Chairman;* Grace Ross, Detroit, Mich.; Ann Dickie Boyd, Denver, Colorado.

Committee on Membership and Stimulation of Fellowship in Public Health Nursing Section: Alma C. Haupt, New York, *Chairman;* Ruth Houlton, Minneapolis, Minn.; Zoe LaForge, Birmingham, Ala. (Allocated to *Committee on Fellowship and Membership.*

Committee to Study Nursing Services in State Health Departments in Coöperation with the N.O.P.H.N.: Marion W. Sheahan, Albany, New York, *Chairman;* Margaret East, Louisville, Ky.; Olivia T. Peterson, Minneapolis, Minn. (Allocated to *Committee on Administrative Practice.*

RECENT APPOINTMENTS

Gertrude Pritchett has been appointed Director of Nurses of the newly organized Columbia County (N. Y.) Department of Health.

Elizabeth Waterbury, formerly of the New York State Department of Health, became a supervisor with the Philadelphia Visiting Nurse Society on March 1.

Ruth E. Grant has been made supervisor of nurses in the Babies' Milk Fund Association of Cincinnati, O.

Ruth E. Mettinger, formerly Red Cross Nursing Field Representative, is now Director of the Bureau of Public Health Nursing in the Florida State Board of Health.

✝

Colonel Theodore Roosevelt was elected president of the National Health Council at its annual meeting recently in New York City.

Other officers elected: Vice-president, Timothy Newell Pfeiffer; secretary, Dr. Donald B. Armstrong, vice-president of the Metropolitan Life Insurance Company; treasurer, Frederick Osborn, of G. M.-P. Murphy & Co.

WINNERS IN IMPROVISED EQUIPMENT CONTEST

First Prize—$25.00 to Velma Brenneman, School Nurse, La Junta, Colorado.

Entry—Reference Notebook for Health Education Material. A loose-leaf notebook into which are clipped health leaflets and pamphlets on all subjects, which the nurse makes available to the teachers for reference in their health education programs.

Second Prize—$20.00 to Mrs. Ella V. Gerry, Nurse with the John Hancock Mutual Life Insurance Company, Hopkinton, Massachusetts.

Entry—Baby Scales. Improvised from a family weighing scale and a wire dish drainer.

Third Prize—$15.00 to Mrs. Margaret B. Milne, Visiting Nurse Association, Chicago, Illinois.

Entry—Invalid's Chair. An arm chair with wide supporting arm, made of a kitchen chair, placed on casters.

Honorable Mention—

Charlotte M. Inglesby, Savannah Health Center, Savannah, Georgia.

Entry—Health Habit Poster. For work with individual child needing special health supervision.

Catherine Courtney, Nurse with U. S. Indian Bureau, Oglala, South Dakota.

Entry—Inhalation Burner. Improvised from oil lamp with tin can perforated and cut out to fit over lamp.

"What—No Imagination?" cannot be laid at the door of the public health nurses of the country. Forty-five entries from twenty states baffled the judges for many hours, as they went over the intriguing models and carefully drawn pictures portraying all types of equipment essential in nursing care and health teaching. We are delighted that a health teaching exhibit was awarded first prize, since this kind of material was particularly mentioned in the contest announcement.

The editors are greatly indebted to the many competitors whose ingenuity and zeal made possible one of the most interesting contests that the magazine has conducted. The winning entries together with two or three others receiving honorable mention will be on display at the magazine booth at the Biennial Convention in Washington.